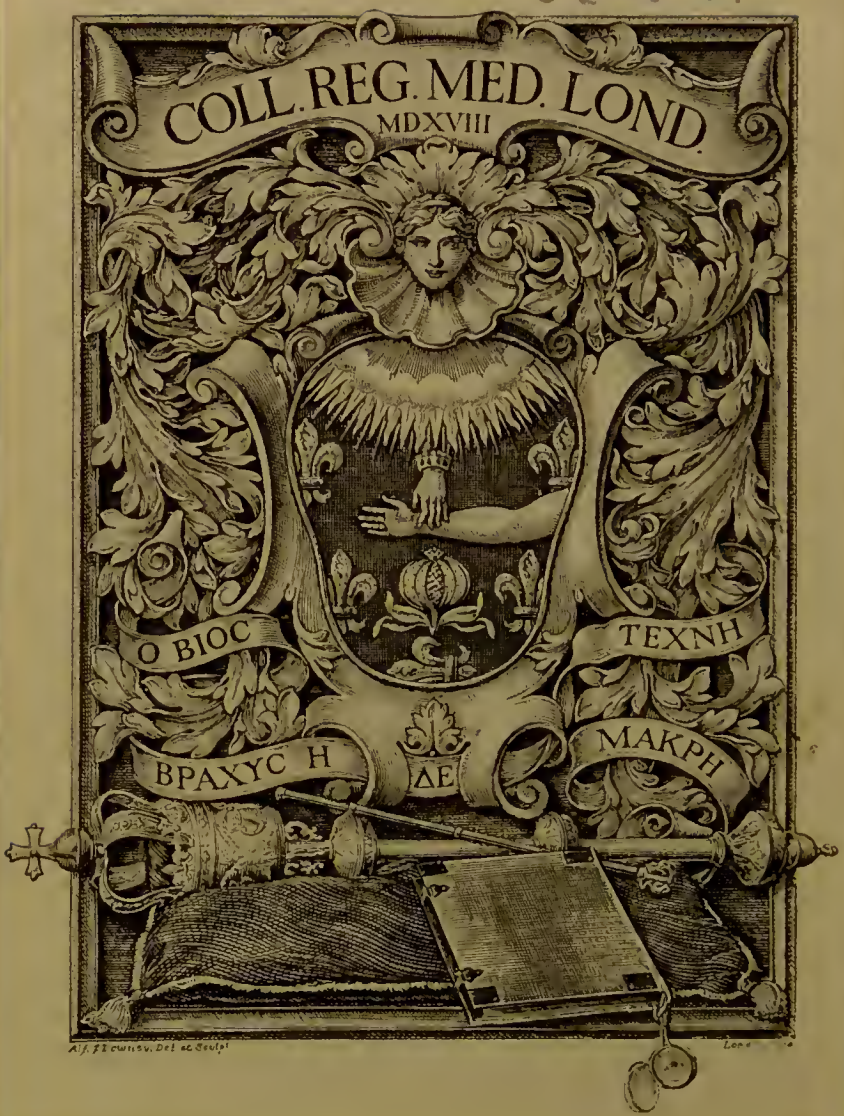
INSANITY

E.G.YOUNGER



INSANITY IN EVERY-DAY PRACTICE

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BY

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PREFACE TO THIRD EDITION

The demand for a third edition of this book is gratifying, as a proof that it continues to fulfil a recognised want.

In this issue I have rewritten a part of the section on General Paralysis, in view of recent lights thrown upon the etiology and pathology of this disease; I have devoted some lines to the subject of Influenzal Insanity, and have included a short summary of the new Mental Deficiency Act—a measure which promises to deal satisfactorily with the long-standing difficulties relating to the care, control, and education, where possible, of a numerous and afflicted class.

It may interest my readers to know that the appreciation of the book is not limited to the English-speaking races. It has been translated into the Chinese language by Mr. Maison J. Chu and Dr. Philip B. Cousland, and is now published in Shanghai. I believe it is the first European work on the subject to have been translated into that tongue.

E. G. YOUNGER.

Mecklenburgh Square, W.C.
June, 1914.

PREFACE TO FIRST EDITION

THERE is no need to point out to the general practitioner the necessity of an acquaintance with the broad outlines of insanity. The aim of the present monograph is to supply that want, so far as may be, within the compass of so brief a treatise. For further knowledge and information the medical man must be referred to one of the excellent larger treatises which may be found on the shelves of any of our special libraries. It must be clearly understood that this monograph is an outline chart, and in no sense a detailed reference map.

E. G. YOUNGER.

MECKLENBURGH SQUARE, W.C.
February, 1904.

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INSANITY IN EVERY-DAY PRACTICE

PART I

I. INTRODUCTORY AND GENERAL

The general practitioner of the present day requires an every-day knowledge covering so wide a field that now and then he must necessarily meet with some case with which he is unable for the moment to deal. As a rule he has neither the leisure nor the opportunity to search for special information in one of the large treatises. This difficulty is specially likely to happen in regard to mental diseases, of which many a man now in busy practice has never studied a single case during the whole of his student career. Instruction in these diseases has now for some time formed a compulsory part of the medical curriculum, but I find the knowledge thus gained soon evaporates, and the medical man with no practical experience of psychological medicine often finds himself at a loss if brought suddenly face to face with a troublesome mental case, with all its problems as to diagnosis, prognosis, and treatment, each requiring to be promptly dealt with, to say nothing of possible future medico-legal complications. Such a man will, I think, gladly welcome a small book to which he may turn with

a reasonable hope of finding the help he wants, and the perusal of which in leisure moments may enable him to grasp the main outlines of diagnosis and prognosis in the ordinary forms of mental disease. Beyond this I do not hope to go, for I am strongly of opinion that it is only those who have lived and worked among the insane for years who can be depended upon to distinguish between and arrive at a prognosis upon certain forms of insanity in appearance closely allied though really widely different, and even then not always until after prolonged and close observation. At the same time, a great deal of help may be given to the practitioner, especially in enabling him to deal promptly with cases of emergency.

I shall endeavour to treat my subject throughout from a practical standpoint, and place myself, as far as I possibly can, in the position of the medical man who, with little or no previous knowledge of insanity, has to deal with a case of mental aberration at a moment's notice.

A lunacy case in general practice will in all probability come under notice in one of the following ways:

(*a*) It may occur in a patient already well known to the practitioner, and often seen by him. Such a case will present but few difficulties in diagnosis, as the latter will have been able to watch and note the more or less gradual departure from the patient's normal mental and moral standard; the change in habits and in temper; the probable insomnia; perhaps the development of sensory hallucinations, and their gradual crystallization into delusions. The principal difficulty here will often be that of convincing the patient's relatives and friends of his or her insanity, and perhaps of the necessity of prompt removal to an asylum, in, say, such a case as puerperal mania.

(*b*) The practitioner may be called to see an absolute stranger, more or less acutely insane, perhaps recently arrived at an hotel or a boarding-house, of whose history and antecedents no account can be obtained, but whose case, nevertheless, requires to be immediately dealt with.

(*c*) He may be called to the assistance of a magistrate, under the Lunacy Act, to examine, and if necessary certify, a patient or patients at a workhouse. In many workhouses this duty is carried out by the medical superintendent, but some magistrates prefer to call in their own medical attendant, and I have known of cases where that gentleman, on his first advent at the workhouse, has never before seen a lunatic, and has had to trust mainly to the knowledge of the magistrate himself and the suggestions of the relieving officer.

(*d*) Under Section 13 of the same Act, the doctor may be ordered by a magistrate to visit, separately from any other practitioner, the home of a patient, and to certify the latter if necessary. These are often cases where the patient's insanity is so doubtful that the relieving officer or the police inspector does not feel justified in removing him to the workhouse on his own responsibilty. Such patients often require most tactful and delicate handling, and visits to them are not always devoid of an element of danger.

(*e*) He may be called upon to visit and report upon a patient who is already in an asylum under certificate.

(*f*) He may have to decide whether to accept or decline as a resident patient in his house a person whose friends wish to place him under private care.

Many of the above-mentioned cases may require to be certified outright, or may perhaps be left for a few days under skilled observation, pending a diagnosis. Or, on the other hand, the case may prove to be one not re-

quiring care and control at all, or may even turn out to be a case of malingering. I have known of more than one instance where a criminal has feigned insanity in order to get admitted to an asylum, and thus avoid for a few months the hue and cry of the police.

In every case of real or supposed lunacy it is important, without loss of time, to make careful notes, both of one's own observations and of the statements of the relatives and friends. Any case may later involve the necessity of the practitioner giving evidence in a court of law.

It is well to remember that the febrile delirium of pneumonia, of enteric fever, of typhus, of malaria, of meningitis, and so on, does not constitute insanity; neither does the delirium of intoxication.

2. DEFINITIONS OF INSANITY

There have been innumerable attempts to define insanity, both from a medical and from a legal standpoint, and none of them can be regarded as wholly satisfactory. The main difficulty lies in the fact that the standard of mental health is in itself so variable in different individuals that it is impossible to fix any hard-and-fast line between sanity and insanity. This line is rather replaced by a belt or borderland of no-man's-country. Acts which in one person would place him in the region of undoubted insanity, in another of lower mental calibre or of lower social status might pass unnoticed. Eccentricity, also, has to be reckoned with.

A good definition of insanity, so far as definitions go, was one propounded many years ago by Dr. Combe—viz.: 'A morbid action in one, in several, or in the whole of the cerebral organs; and, as its necessary consequence,

functional derangement in one, in several, or in the whole of the mental faculties which these organs subserve.' This hardly covers moral insanity.

Bucknill's definition is likewise a good one: 'A condition of the mind in which a false action of conception or judgment, a defective power of the will, or an uncontrollable violence of the emotions and instincts, have, separately or conjointly, been produced by disease.'

Conolly defined insanity as 'An impairment of one or more of the faculties of the mind, accompanied with, or inducing, a defect in the comparing faculty.'

Dr. Robert Jones has defined it as 'A change of conduct either as regards the individual himself or in respect to his environment.'

The shortest definition I know of, and one that is, perhaps, the most generally correct, is: 'Insanity is a perversion of the *Ego*.' But this is almost too laconic to be altogether satisfactory.

It may happen in a court of law that the medical witness is asked to define insanity. I strongly advise him to decline to make any such attempt. I know of no definition which covers the whole of the ground, and the witness may find himself led into a pitfall.

3. CAUSES OF INSANITY

It has been usual to divide these primarily into predisposing and exciting, and each of these again into moral (psychical) and physical. The term 'predisposing' is now, however, falling into disuse, owing to the rather tardy recognition of the fact that heredity is the principal predisposing cause of nearly every form of insanity.

Heredity.—It is to be borne in mind that hereditary tendency need not be of actual insanity, but may be that

of other neuroses, and that an heredity of epilepsy, hysteria, hypochondriasis, nervousness, or alcoholism, may, among some others, lead to insanity in a descendant. The converse may also be the case. Sir George Savage has most truly said: 'The person with a weak nervous system is likely to beget children with weak nervous systems also.' It may here be mentioned that the Commissioners in Lunacy in their report for the year 1908, acting upon the suggestion of the Special Committee of the Medico-Psychological Association of Great Britain, adopted a greatly expanded list of the causes and associated factors of insanity. In this list, under the heading 'Heredity,' which is given a wide significance, including collateral as well as immediate relationships, there are found conditions of insanity itself, of epilepsy, of neurotic states, embracing such functional affections as hysteria and neurasthenia, spasmodic asthma and chorea, a marked degree of 'eccentricity'—a term the use of which must largely depend on the view taken by the investigator as to normal conduct—and alcoholism. According to the Commissioners' report for the year 1912 there was, in the yearly average of total admissions to asylums in the years 1907 to 1910, an insane heredity (excluding the wider significance of that term mentioned above) of per cent:

	Males.	Females.
Private patients - -	18·2	27·2
Pauper „ - -	21·1	25·9

Dr. Easterbrook, late of the Ayr District Asylum, believes that the neuro-insane constitution is present in nearly 58 per cent. of his cases, and this is probably very near the mark in most asylums. Sir George Savage says that in his experience at least one-third of all the patients admitted into asylums have insane blood relations. It is

often difficult to ascertain the whole truth, or, indeed, any of the truth, about heredity from the patient's relatives, and concealment of important facts is constant. It is a common experience of the asylum medical officer, when taking a patient's history from a relative who may himself have neurosis writ large on his forehead, to find that person deny strenuously all knowledge of a history of insanity in the family, only for the doctor to discover later from a more truthful informant (probably a 'friend' and not a relative) an altogether opposite state of affairs. The doggedness with which the members of some neurotic families will deny the heredity of insanity to the psychologist is only equalled by the readiness with which they divulge it, and the assiduity with which they hunt for records of it, when their relation has got into the hands of the police instead of into those of the asylum officials, and when a plea of insanity is likely to prove useful.

It is generally considered that a father is more likely to pass his insanity on to his sons and a mother to her daughters. The insanity of the mother, however, is looked upon as more dangerous to her daughters than is that of the father to the sons. Dr. Mott thinks that one reason for this may be that the daughters, being at home, come more under the mother's influence. In these cases of direct heredity the same form of insanity may be transmitted, or it may take a different direction in the descendant, but it should always be remembered that suicidal tendency is specially prone to propagate itself. It is now thought that the general tendency is for insanity not to proceed beyond three generations and that as a rule there is either a regression to the normal or the stock dies out, often from tuberculosis.

Sex.—There are under certificate in England and

Wales, and in practically every individual asylum, more women than men, from which it might be hastily inferred that women are more prone to become insane than men; but we have to bear in mind that in our population women are in excess, also that it is an ascertained fact that female chronic lunatics live longer than male ones, thus swelling the floating population on the female side of the asylums. It is true that general paralysis, so common among men, is comparatively rare among women (though, unfortunately, not nearly so rare as it formerly was); but, on the other hand, the woman runs many special risks during the periods of pregnancy, parturition, and lactation, not to mention menstrual and climacteric troubles. Evidence points on the whole to the probability of insanity being slightly more frequent in the female sex.

Age.—No age is exempt from insanity, but there are certain periods of life at which it is commonest. Excluding for the moment the question of heredity, idiocy may be due to intra-uterine causes, and both that and imbecility to risks at birth, and imbecility to the neuroses incidental to dentition. Since the discovery of the Wassermann reaction certain observers have come to the conclusion that parental syphilis is the cause of idiocy and imbecility in many more cases than had hitherto been suspected. Attacks of insanity are rare under the age of puberty, and when met with are oftener seen in private practice than in asylums. The age of puberty is fraught with psychological dangers to both sexes, and especially to young people of neurotic inheritance. Hypochondriacal symptoms are common in pubescent insanity, though instead of depression there may be exaltation. Self-abuse often, and other moral perversions sometimes, are distressing accompaniments.

In active adult life—twenty-five to fifty-five—the commonest forms of insanity are mania, melancholia, general paralysis, and, less often, some forms of dementia. A little later melancholia predominates, and it may here be mentioned that this is especially the case in women at the time of the menopause, when the patient not infrequently flies to alcohol for comfort, thereby adding fuel to fire. Later still, there comes in both sexes the period of decadence and of vascular changes, leading to senile dementia and similar degenerative diseases.

The opsonic index is low in all forms of insanity.

Amenorrhœa is common in all cases of insanity in females.

Most of the exciting causes of insanity will be dealt with in the ensuing pages as occasion may arise, but a few words here as to the influence of alcohol as a cause may not be amiss.

That alcoholic excess is a potent cause of insanity is universally admitted, but there is considerable room for doubt whether insanity caused by alcohol is so general as the discourses of some temperance reformers would lead us to suppose. No one can deny that the immoderate use of alcohol tends to grave vascular changes, with consequent degeneration of certain organs and ultimate shortening of life; nor is there the least doubt that the great majority of mankind are better without any alcohol at all, especially in adolescence and in earlier manhood. Neither can it be denied that alcohol is a frequent cause of crime; but as a cause of insanity I think its influence has been exaggerated. It is customary for teetotal orators to tell us that 50 per cent. of the admissions to our asylums are due to drink. This statement is founded on one made many years ago by the late Lord Shaftesbury before a Select Committee on lunatics, and he in his

turn trusted to a statement made by Esquirol; but, according to Bucknill and Tuke, it is more than doubtful whether Esquirol possessed any statistics which would have borne him out in his assertion. According to the Lunacy Commissioners' Blue-Book for the year 1912, the proportion per cent. of admissions to asylums due to intemperance in drink during the years 1907 to 1910, was:

	Males.	Females.
Private asylums - -	2·1	2·1
Pauper „ - -	5·3	5·7

Here we have statistics sifted by properly qualified observers. The proportion is much below the *ex parte* computations of the temperance platform. The somewhat higher number of admissions due to alcohol to the pauper asylums as compared with the private ones is doubtless to be partly accounted for by the inferior and poisonous quality of the liquors drunk by the poorer classes, and partly by the less temperate habits of these classes.

To my mind the question of alcoholism as a cause of insanity is so closely connected with that of heredity that we can never hope to arrive at any approximately correct statistics as to the share which each takes in its causation. Alcoholism is in itself looked upon by some authorities as one of the best-known and most universally admitted hereditary neuroses, though, on the other hand, it has been denied that the transmission of an acquired character, such as a craving for alcohol, can ever take place. I knew a family where an alcoholic father and a phthisical mother had five sons. Every one of these sons took to drink, and they all died under forty, two of general paralysis, and the remaining three of phthisis, brought on by irregular lives acting on an heredity of

phthisis. Surely heredity of intemperance must also have had something to do with the youthful drunkenness of all these young men.

It is to be borne in mind that drunkenness is almost as often an early symptom as it is a cause of insanity, especially in general paralysis. The patient's friends may attribute his mental trouble to an immediately anterior outbreak of alcoholism, whereas careful inquiry will commonly, in these cases, antedate the incidence of insanity by many months.

If we exclude general paralysis, as being essentially a luetic disease, I believe heredity and drink to be the two principal causes of insanity, but that the influence of the first has been underrated and that of the second overrated.

4. HALLUCINATIONS, ILLUSIONS, AND DELUSIONS

It will be well to devote a few lines to the consideration of the above three manifestations in order to differentiate between them, especially as they have been by some authors rather loosely classified. I shall give the generally accepted views.

Hallucinations are *false* perceptions of the senses; for example, visual hallucinations, so common in acute alcoholic insanity, or hallucinations of hearing, taste, and smell, common in melancholia. They are among the most usual symptoms of several kinds of insanity, but, on the other hand, a person may labour under hallucinations and yet not be insane. He may be able to recognise that they are nothing but hallucinations, and subjective in nature. A familiar example of this condition is the auditory hallucinations, such as hissing or singing, connected with middle-ear disease. Or, again,

a patient in the incipient stage of threatened insanity may suffer from hallucinations which he recognises as such. He will perhaps say, 'I hear the voices of children,' or, 'I see a face glaring at me from the corner of the room, but I am quite sure that it is all my fancy.' Later, if his insanity becomes more confirmed, he will begin to believe in these hallucinations; his judgment fails, and the fleeting subjective hallucinations merge gradually into fixed delusions.

Illusions are *mistaken* perceptions of the senses. The patient does actually see, hear, or feel something, but he mistakes it for something entirely different. He may mistake a creaking cart-wheel for a bird singing, or the running of a distant water-tap for the hissing of a caldron in which he is going to be boiled. He may see clouds in the sky, and mistake them for armies fighting in the air.

If a patient believe in his hallucinations or illusions, that patient is insane.

A delusion is a false belief—a belief in the truth of that which is not true. Brower and Bannister (American authors) define a delusion as follows: 'A false belief that is incompatible with the training, education, and general environment, of the individual; and, moreover, should be as to a matter of fact, or should be contrary to the usual habit of thought of the individual.' They own, however, that this definition has obvious defects. A delusion may have reference to the senses, as described above, or it may be quite independent of these, as where a man fancies he is God or the King, or that he has committed the unpardonable sin.

A person who has delusions is necessarily insane.

5. EARLY AND PREMONITORY SYMPTOMS OF INSANITY

A proper recognition of these symptoms is of importance, as prompt and judicious treatment will often save the patient from an impending attack. In nine cases out of ten, however, the physician is consulted too late; the insanity has developed itself, mental alienation is complete, and any line of treatment is useless except that of placing the patient under certificate. Even under such circumstances a diagnosis of early symptoms and an ability to prove their existence may be of great use, as in the case of a disputed will or other legal document.

It is usual among the public to picture an attack of insanity as coming on suddenly, whereas in nearly all cases the onset is gradual. Even in acute mania there is often a short foregoing period of depression.

Although sometimes the early symptoms may be well marked and unmistakable, they are more commonly so slight and apparently trivial that they pass almost unnoticed by the friends, and may even be underrated by the family physician, unless he be in constant attendance or be an intimate friend of the patient.

On being called to a person who is undoubtedly insane, it is quite common for the doctor to be told by the friends that the patient was quite well until a few days before; but a little inquiry will generally elicit a history of earlier symptoms, showing that he has for some time been passing through a stage known as emotional alteration. He may have neglected his occupation for no particular reason, except that he did not feel equal to it. For weeks, or perhaps months, his general nature and habits have altered, though almost imperceptibly:

the even-tempered person has become irritable, discontented, snappish, and impatient of contradiction; the alert and intelligent one has become dull and lethargic; headache has been a marked symptom; the spirits have been depressed, or periods of depression have alternated with excitement. Last, but by no means least, insomnia has been present. Of all the incipient symptoms of insanity, insomnia is the most important and the most often present, and the greater the sleeplessness the more rapid is likely to be the process of mental deterioration, and the nearer the time when the hallucinations, at first recognised by the patient as such, become fixed delusions, and he becomes a lunatic. If the medical man is fortunate enough to be called in at an early stage of the period of emotional alteration, it is by treatment of this insomnia that the tired and irritable brain gets its best chance of recuperation, and an impending attack of insanity may be warded off. It is in these cases that such drugs as chloralamid, trional, and sulphonal, judiciously administered, and their effect carefully watched, often prove useful, though in cases of developed insanity hypnotics are, as a rule, worse than useless. Warm baths also, with or without cold affusion to the head, will sometimes in these early cases procure refreshing sleep without the use of any drug at all.

It may be mentioned here that sometimes the patient can give more information about the premonitory signs than can the friends. He has become conscious that he has lost his capacity for work, or, at any rate, that something is amiss with him, but has been loth to trouble his relations with his ailments. He will generally, however, tell his doctor when closely questioned.

So far I have confined myself to the description of early symptoms which, if recognised and treated in good

time, may improve, or disappear. There is one form of insanity, however, the initial symptoms of which demand separate consideration, and which it is of importance to detect early—not for curative purposes, for the disease is incurable so far as our present knowledge goes—but to protect the patient from himself, and his family from probable financial ruin. I allude to General Paralysis of the Insane. In this hopeless disease prompt certification is of great importance for many reasons, but mainly for the following one: that, owing to expansive delusions of wealth and grandeur, the patient is unfit almost from its onset to conduct the affairs of business life with any reasonable care and caution, and he may soon squander the little money still remaining from his already neglected business, and, unless curbed, may leave his wife a penniless widow and his children paupers.

6. EXAMINATION OF PATIENT WITH VIEW TO CERTIFICATION

There are few duties which carry with them greater responsibility than that of deciding for the purpose of certification whether a person is of sound or unsound mind, and few that require greater patience, with knowledge of the world and of human nature. To discharge them properly demands a keen faculty for sifting and appraising the statements made by the friends. Of the latter, some may be biassed in the patient's favour, much as others may be prejudiced against him and anxious for his removal from home. A mistake on one side may involve the patient's needless removal to an asylum, with all the accompanying distress of mind and social unpleasantness connected therewith, besides the likelihood of the certifying practitioner having later to defend

an action for malpraxis in the High Court. On the other hand, a failure to recognise the symptoms may leave a dangerous homicidal or suicidal lunatic at large. Thirdly, the inability to arrive at a conclusion is humiliating to the medical attendant, is talked of in the neighbourhood, and is tolerably certain, sooner or later, to injure his reputation.

In some cases, as in those of acute mania or of developed general paralysis, the diagnosis will present no difficulties, but in others it may not be easy to arrive at an opinion at the first visit.

On going to see a patient presumed to be of unsound mind always carry a note-book. The notes you make cannot be too full in view of possible eventualities. On entering the house, and before seeing the patient, ask for an interview with the nearest relation or friend for the purpose of learning particulars of the case, if this has not already been done. Enter the patient's name in full, address and occupation; also the name in full, address and degree of relationship, if any, of the informant. These will be required for the certificate, should the patient be certifiable, and it is well to have them on paper before proceeding farther. Nothing is more awkward when writing a certificate at home than to find you cannot give, say, the address of the informant in the 'facts communicated by others' without sending round to inquire, and if this be not filled in the certificate will certainly be sent back for correction by the Lunacy Commissioners. This is one of the commonest mistakes made by novices.

Obtain from your informant a full history of the case. Inquire into the patient's previous habits and disposition, and as to what changes have taken place in these, and how recently. Find out whether there have been

previous attacks, and also seek for any history of a blow on the head or of fits. Inquire as to sleep, and as to mutterings to imaginary persons. Get the relation to give the immediate cause of his or her wish for your opinion on the patient. Then take the family history, with especial reference to heredity of insanity, drink, epilepsy, suicide, and so forth. If the informant be a near blood-relation, observe whether he or she is of average physique and of good intelligence, or whether there are evidences of neurotic tendency or imbecility. If other relations are in the house and are willing to give information, take it, and in considering your decision compare their statements one with the other, and afterwards with the statements of the patient himself. Always bear in mind, as I have already mentioned, that the statements of the near relations in a case of hereditary insanity are often untrustworthy. If a nurse be in attendance on the case, take her information also; it is independent and often valuable. This, as well as the statement of the nearest relative or friend, may well be used in the certificate, and the rest of the evidence can be kept for reference if required. It once fell to my lot to be consulted in a case where the informant instead of the patient proved to be labouring under delusions. I had been asked by a lady to examine into the mental condition of her husband, who, she was convinced, was becoming insane. She gave me a long list of symptoms, including his sleeplessness, his alteration for the worse in temper, and his squandering of money in rash speculations. It struck me that her own manner was excitable, but she told a most coherent and plausible tale. When I saw the supposed patient, I found him to be an amiable, harassed man, who had been suffering for many weeks from his wife's insane vagaries, and who ought to have

taken some steps in the matter long before. He now evidently felt bound to speak, if only in self-defence, and he soon put a very different complexion on the matter. Of his perfect sanity there could be no possible doubt, nor could there be any that the wife's statements were, at the best, gross exaggerations. As a fact, he had certainly lost a small sum of money, but not in speculation, and he soon gave me good reasons for his sleeplessness and alteration in temper; for his wife, who had a very bad hereditary history of insanity, and who had herself been in an asylum a few years before, labouring under delusions of persecution, had lately become restless again; had talked all night; had neglected her household duties; had told many of the neighbours that she was sure her husband would become insane unless he took a complete rest from work; had expressed her intention of approaching his employers on this subject; and had actually been to another medical man beside myself with a view of getting the unfortunate man placed under certificate. Everyone of these statements of the husband I was afterwards able to verify by inquiries among relations, and I eventually formed an opinion that the wife was on the eve of another outbreak of insanity, which her husband had long suspected, and which proved to be the case. She was then placed under certificate but was soon afterwards taken from the asylum on the responsibilty of a wealthy lady who maintained that the patient was sane, and who started her in a boarding-house which, however, she failed to manage properly. She was found dead in her bedroom one morning of coal-gas poisoning, having made an ineffectual attempt over-night to induce her two children to sleep in her room.

Interview with the Patient.—Sometimes this can be arranged with the greatest ease, at others only with

difficulty, owing to the patient's suspicions of strangers. If he be a general paralytic, a chronic alcoholic, or a senile maniac with grandiose ideas, he will welcome the stranger with open arms, and will plunge into the subject of his private affairs, his Utopian schemes, or his imaginary grievances with the utmost readiness; but if he be a suspicious melancholiac or a sufferer from delusional insanity, it is often difficult to approach him. Each case must be dealt with on its merits, but any deception of the patient is much to be deprecated. It has been said that the utmost amount of dissimulation allowable in obtaining access to a patient is that of letting him think you have been called in to see some other member of the family, and then taking the opportunity of having an interview with him, and I agree with this. I strongly urge upon my readers to insist upon being introduced in no other character than that of a medical man. The patient is almost sure to detect the deceit sooner or latter, unless he be acutely maniacal or hopelessly demented, and besides the immediate unpleasantness the discovery may cause, the effects on him may be unfortunate, and may even jeopardize his ultimate recovery. If he be a suspicious person, full of delusions of persecution, he will not forget the deception by a doctor, and will always mistrust doctors thenceforth wherever he may be, whether in an asylum or under private care. Every alienist physician knows that complete trust in the doctor is one of the most important elements in promoting the recovery of an insane patient. The friends, in their timidity, will often say that they know the patient will flatly refuse to see a doctor, but the event usually disproves this, and the alternative is worse. On one occasion, much to my dismay, and before I had an opportunity of protesting, I

was introduced as a commercial traveller. The patient was a stationer, whose family history was riddled with insanity, and who was himself the subject of delusional insanity. I failed to sustain my rôle, and he speedily found out the deception, though not before I had been able to ascertain the facts indicating insanity. The other certifying doctor, however, who arrived soon after my departure, found the patient on his guard and in an excited and threatening mood, met with a bad reception, and retired without feeling himself able to certify. This case has always impressed itself on my memory from the curious chance that ten years later I had to place under certficate the son who had introduced me as a traveller. The son's case was almost a replica of the father's, but he had, fortunately, forgotten my identity.

On being introduced to the patient, the doctor will have to employ the tact of a man of the world in order to get on good terms with him. If the patient protest against his privacy being invaded by a strange medical man, as he well may do, it may be necessary to tell him candidly that it is by wish of his friends, or of his own doctor, as the case may be, that a further opinion is sought on the subject of his health. If he asks if he is suspected of being a madman, it may even be wise to tell him that you have been asked to examine into his mental condition, but that you are perfectly unbiassed, and it will be a real pleasure to you to find yourself able to report that his sanity is undoubted. In all probability he will then soon settle down to amicable conversation.

On entering the patient's room, the physician must have an eye everywhere. He must observe any peculiarities in dress—whether slovenly or overspruce, fantastic, or decorated with ribbons, feathers, extra buttons, and so on. He must note the patient's expression—

whether sad, or vacant, or elated, haughty and arrogant, or tearful and self-abased. The expression will usually indicate the trend of the delusions. He must observe whether he makes any odd gestures, or turns suddenly to any part of the room, as if listening to voices; or gazes fixedly in one direction, as if seeing something; or smiles, or frowns, or shakes his head without apparent cause. Mutterings and whisperings will, of course, be duly noted. If the ears be plugged with cotton-wool, or be tied up in an extemporized bandage, it will generally come out on inquiry that this has been done to keep imaginary voices away.

After a short preliminary conversation, a good plan is to make a physical examination of the patient. If this should produce no diagnostic result, it at any rate puts the doctor and patient on something like good terms, and opens the door to conversation, when his enumeration of his subjective symptoms will often be accompanied by a denunciation of his supposed persecutors for causing these, and he will then reel off quite a string of delusions. A question or two about appetite and relish for food may elicit hallucinations of taste or delusions about poison.

The memory should be tested for both recent and remote events. This may easily be done by questioning the patient as to his place of residence: how long he has lived there, where he lived before, and how long; the names and ages of his children, the events of the current day and of the past week.

If the patient be talkatively inclined, let him talk on and do not interrupt him. Presently his talk is sure to drift to his fancied grievances or ailments.

If he maintains an obstinate silence, do not waste much time or trouble in inducing him to talk. In these cases of great taciturnity it may be necessary to pay a second

or even a third visit to the patient before arriving at a decision. Especially careful notes should, however, be made as to his aspect, expression, attitude, or gestures. These, if irrational, should be included in the certificate, and will count. It is by no means necessary to include delusions in a certificate, though it is more satisfactory. In this connection I may mention that where an interview with the patient fails to reveal any delusions, it is often of the greatest possible assistance to get hold of some of his writings, such as letters, memoranda, or diaries. Some lunatics, especially paranoiacs, will commit their delusions to paper when they will not talk about them. I recently had an excellent illustration of this. An elderly gentleman with heredity of insanity had, after a period of insomnia and depression, made an attempt to commit suicide by poison. When I saw him several days afterwards, in consultation with his own medical man, he was plunged in melancholy, but quite coherent. He admitted having attempted to poison himself, but he either would not or could not give any reason for the act, and we both failed to find any actual delusions, though we agreed that he was insane and certifiable. Later on, however, we got hold of a kind of diary he had kept, which had been found in his pocket, and here we discovered numerous delusions written down, one being that he had committed a crime which had ruined his wife and children, and had rendered him no longer fit to live. Though the existence of delusions was not actually necessary for our certificates, yet the inclusion of them strengthened these materially.

Remember that some patients, especially the better educated ones, will often conceal their delusions. Though themselves firmly believing in them, they soon find that others do not, and therefore argue with themselves that

it is unwise to talk about them. One of the most difficult cases to deal with is a case of delusional insanity who has already been in an asylum, who knows perfectly well the aim and object of your visit, and who will therefore, if his brain possess the necessary inhibitory function, conceal his delusions to the utmost of his power.

Another difficulty may arise where a man supposed to be insane accuses his wife of infidelity. This is one of the commonest of insane delusions, especially in alcoholic cases, but, on the other hand, it may be no delusion at all. In the absence of corroborative evidence, you have merely the patient's statement on the one side and his wife's denial on the other. If you come to the conclusion that the statement is a delusion, and you include it as such in your certificate, state your reasons for your opinion.

7. LEGAL BEARINGS

(*a*) England and Wales

All proceedings in lunacy are conducted under the Lunacy Act, 1890, An Act to Amend the Lunacy Act, 1891, An Act to Amend the Lunacy Acts, 1908, and another short Act, 1911.

The *Lord Chancellor* has supreme control of all matters connected with the insane.

The *Masters in Lunacy* conduct inquiries into the sanity of patients where property is involved, and where guardians of the patient or of his property have to be appointed. Such guardians are known as the committee of the person and of the estate respectively.

The *Lord Chancellor's Visitors* visit periodically the patients found lunatic after such inquiry.

The *Commissioners in Lunacy* exercise supervision over

all those who have charge of lunatics, pay visits to all asylums, and are the guardians of all insane patients. They have the power of ordering prosecutions for non-observance of their regulations, and, if they think it necessary, they can apply to the Lord Chancellor for an inquiry into the administration of any insane person's property. These are some only of their manifold powers.

For the purpose of discussing procedure in placing an insane patient under control, it will be convenient to divide lunatics into two classes—pauper and private. For the former, accommodation is provided in county and borough asylums, and, temporarily, in the lunatic wards of the workhouses.

Private patients, on the other hand, may be placed in licensed houses—that is to say, private asylums—in lunatic hospitals, or as 'single' patients in houses where no other insane patient is kept. No license is required for the keeper of such a house, and, with the consent of the Commissioners, more than one patient may be received under certificate.

It is illegal to keep in a private house for profit a lunatic not under certificate. Evasion of this rule is not uncommon, but should the Commissioners hear of it a prosecution will assuredly follow. In the latter event the defendant will be put to a great amount of anxiety and expense.

Pauper Lunatics.—The Act directs that:

(*a*) Every medical officer of a union who has knowledge that a pauper in his district is a lunatic shall, within three days, give notice to the relieving officer, or, if there be no relieving officer, to the overseer. That officer, in his turn, shall, within three days, give notice thereof to a 'justice having jurisdiction' where the pauper resides, who shall, within three days, require the

relieving officer or overseer to bring the alleged lunatic before him for examination.

(*b*) A similar duty devolves upon any relieving officer or overseer who may have knowledge of a pauper deemed to be a lunatic, whether by notice from a medical officer or otherwise.

The 'justice having jurisdiction,' or the 'judicial authority,' is a justice of the peace specially appointed to deal with lunatics. County court judges and stipendiary magistrates also count as 'judicial authorities.' The names and addresses of the local judicial authorities will be furnished on application to the inspector at the nearest police-station, or at any police-court.

(*c*) Every constable, relieving officer, or overseer of a parish who has knowledge of any person, whether a pauper or not, who is a wandering lunatic, shall immediately apprehend and take the alleged lunatic before a justice. Or the justice, hearing of such wandering lunatic, may issue an order for his apprehension.

(*d*) Every constable, relieving officer, or overseer who has knowledge that any person within his district who is not a pauper, and is not wandering at large, is deemed to be a lunatic, and is not under proper care and control, or is cruelly treated or neglected by those in charge of him, shall, within three days, give information on oath to a judicial authority under the Act. The justice may himself visit the alleged lunatic, and shall, whether making such visit or not, direct any two medical practitioners to visit and examine him, and certify as to his mental state. If from the certificates, or after further inquiries, he is satisfied that the alleged lunatic is not under proper care and control, or is cruelly treated or neglected, and is a proper case to be detained, he may by order direct the lunatic to be detained in any institu-

tion to which, if a pauper, he might be sent under the Act. The Amendment Act of 1891 says that such a patient shall be classified as a pauper until it is ascertained that he is entitled to be classified as a private patient.

(*e*) If a constable, relieving officer, or overseer deem it necessary for the public safety or for the welfare of the alleged lunatic that he should be at once placed under care and control, he may remove him to the workhouse of the union in which the alleged lunatic is, for a period of not longer than three days, during which time such proceedings shall be taken as are required by the Act.

The above five classes of case are those which commonly make their appearance in the lunatic ward of the workhouses, that being the usual place fixed by the justice for making the examination, though he has power to examine at his own house or elsewhere.

In all the above cases, except in that one where the alleged lunatic has already been visited by two medical men, the justice shall call to his assistance one medical man, and direct him to examine the patient, and if he certify that he is insane, and the justice be satisfied of that fact, the latter shall order his detention. He may make a summary reception order, but may suspend its powers for not more than fourteen days, during which time the patient can be detained in the workhouse. This power is useful in the case of a wandering lunatic, whose friends have to be hunted for, but at the present time in London the suspension of a reception order is often a compulsory proceeding, owing to the crowded condition of the public asylums and the difficulty in finding a vacancy.

The justice may decline to make an order if not convinced of the patient's insanity, or he may adjourn the

case for any period not exceeding fourteen days. This latter procedure is advisable in cases of acute alcoholic delirium, where the patient commonly recovers after a few days' treatment, and thus escapes the stigma of having been placed under certificate.

A lunatic as to whom a summary reception order has been made may be placed under the care of a relative or friend, if the judicial authority or the visitors of the asylum in which the lunatic is or is intended to be placed shall be satisfied that proper care will be taken of him.

Remember that in the case of a pauper lunatic all that is usually required to place him under care and control in a public asylum is a justice's order, accompanied by one medical certificate and a statement of particulars. An order may also be made by two or more Commissioners in Lunacy; this also must be accompanied by one medical certificate. It is a course rarely pursued.

Private Patients.—There are two methods of proceeding to obtain the detention of a private patient, not being a Chancery case. One is by ordinary petition (including a 'statement') and two medical certificates, and the other is by urgency order.

In proceeding by ordinary petition, the printed forms required are four in number—the petition and statement, the justice's order, and the two medical certificates. The superintendent of the licensed house to which the patient is about to be removed will always provide these forms, but time is often saved by keeping a few of them in hand. These and the urgency order forms may be purchased of Messrs. Shaw and Sons, Fetter Lane, London, E.C.

It having been decided by two medical men that the patient is insane, the petition and statement, which contain marginal explanatory instructions, must be

filled up and signed by a near relative, or, if such be impossible, by a friend, the reason then being stated on the form why a relative has not been the petitioner. This paper, accompanied by the two medical certificates and the printed form for the justice's order, must be submitted to the judicial authority (see p. 25), or to a county court judge, or to a stipendiary magistrate. It is better in practice to go to one of the first named, as the latter two will often decline to act.

The petitioner must have seen the patient within fourteen days of petitioning. One of the medical certificates must, if possible, be that of the ordinary medical attendant of the patient. If this be not the case, the petitioner must state the reason why on the petition. The medical men must examine the patient separately from each other and within seven days of presentation of the petition. They must not be connected with one another (as in partnership), nor with the petitioner, nor with the person who is to receive the patient.

The judicial authority may at once make the order, or may prefer to examine witnesses first, or may examine the patient himself. The last mentioned is the only really satisfactory course to pursue, and should, in my opinion, be made compulsory in every case. He may postpone signing the order for any period not exceeding fourteen days, or may dismiss the petition.

When all the forms are filled up, they must be delivered to the person who is to take charge of the lunatic. They are his authority for receiving the patient under his care.

The formalities to be observed in proceeding by ordinary petition take time and give trouble, and there are cases in which a more speedy line of action is desirable. Such are those where the patient is acutely maniacal or acutely suicidal, or is so sly that interviews

with two doctors, and perhaps a magistrate as well, will arouse his suspicions and cause him to abscond, if he have a chance, before the papers can be put in force. Here the urgency order is useful.

An urgency order must be made (if possible) by the husband or wife, or by a relative of the alleged lunatic, accompanied by one medical certificate. Each of these must have seen the patient within two days of signing. The order holds good for seven days, within which time an ordinary petition, with two medical certificates and a justice's order, must be provided. One of the certificates may be by the same doctor who wrote the urgency certificate and in the same words, and also as the result of the same interview, if within three days.

Urgency orders should not be made use of except for really urgent cases. They are convenient and often necessary at the moment, but are apt later to cause a good deal of extra trouble all round.

Chancery Lunatics.—The question of these scarcely comes within the scope of this little book, as the solicitors concerned in the case give the medical man all necessary instructions. They are patients generally possessing considerable property, upon whom an Inquisition or Commission in Lunacy is held. Two medical affidavits are required, and these may include facts indicating insanity which have occurred within two years. The inquiry is held before one of the Masters in Lunacy, or sometimes before a Judge of the High Court. If insanity be proved, the finding of the court may be that the patient is of unsound mind and incapable of managing his own affairs, or that, though incapable of managing his own affairs, he need not be restrained personally. The court has the power of appointing a committee of the person and another of the estate, as

mentioned on a previous page. Inquisitions in Lunacy should only be applied for where recovery is unlikely. Should the patient recover, the proceedings can be set aside by another inquiry, known as a 'supersedeas.'

Where the estate is not a large one, it is now usual for the Master in Lunacy to appoint a Receiver without having held an inquisition.

The medical witness should be careful to keep a copy of his affidavit. If he have not done so, he should get a copy from the solicitors before going into court.

In the above section on the legal bearings of insanity in England and Wales, I have confined myself as rigidly as possible to such information as is absolutely necessary for the knowledge of the general practitioner in his dealings with the insane, with a view to their being placed under proper treatment. Much valuable information which has been discarded here may be found in the Lunacy Acts, 1890 and 1891, and the two amending Acts, 1908 and 1911, obtainable from Eyre and Spottiswoode, East Harding Street, Fetter Lane, London, E.C.

It is well to remember that if insanity occur in a person in the humbler ranks of life who cannot afford a private asylum, the proper course to pursue is to communicate at once with the relieving officer, who will take all the necessary steps and relieve the practitioner of all responsibility. This officer will usually expect a line in writing to the effect that, in the doctor's opinion, the person is of unsound mind.

This document should be marked 'Private,' and the envelope should be closed down. Especial care must be taken that it does not fall into the hands of the patient or any of his relations. Such a thing happened a few years ago, when a female patient who had been removed to the workhouse infirmary, but had afterwards been discharged

from thence as not insane, got hold of the loose slip of paper on which the doctor had stated his opinion. She brought an action for libel, and the case was decided against the doctor, the court holding that he had not taken reasonable precautions to render his certificate a privileged communication.

In 1913 there was passed the Mental Deficiency Act, which repeals the Idiots Act, 1886. It came into operation on April 1, 1914, and does not extend to Scotland or Ireland. Mental defectives within the meaning of the Act are Idiots, Imbeciles, Feeble-minded Persons, and Moral Imbeciles. They are classified as under :

1. Idiots are persons so deeply defective in mind from birth or from an early age as to be unable to guard themselves against common physical dangers.

2. Imbeciles are persons in whose case there exists from birth, or from an early age, mental defectiveness, not amounting to idiocy, yet so pronounced that they are incapable of managing themselves or their affairs, or, in the case of children, of being taught to do so.

3. Feeble-minded persons are persons in whose cases there exists from birth, or from an early age, mental defectiveness, not amounting to imbecility, yet so pronounced that they require care, supervision, and control, for their own protection or for the protection of others ; or, in the case of children, that they, by reason of such defectiveness, appear to be permanently incapable of receiving proper benefit from the instruction in ordinary schools.

4. Moral imbeciles are persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect.

All the above may be dealt with as under:

(*a*) By Parent or Guardian.

(*b*) By petition to a Judicial Authority, from any Relative or Friend, or from an Authorized Officer of the Local Authority.

(*c*) By Order of the Court.

(*d*) By Order of the Home Secretary.

If the person is an idiot or imbecile, the Parent or Guardian may place him under control upon certificates signed by two medical practitioners, one of whom must be a practitioner approved for the purpose by the local authority or the Board of Control. If the person is not an idiot or imbecile, and is under the age of twenty-one, he may be placed in an institution or under guardianship, but in that case an additional certificate must be obtained from a judicial authority—*i.e.*, a County Court Judge, a Stipendiary Magistrate, or one of the specially appointed Justices.

For further information the reader is referred to the Act itself, obtainable from Messrs. Eyre and Spottiswoode.

Voluntary Boarders not certifiable as lunatics may be received into licensed houses and hospitals. For the former the consent in writing of two of the Commissioners is required, or, when licensed by justices, of two of the justices; and such voluntary boarders are to be received for a specified time only. For admission to a hospital no such written consent is required, and the boarder can leave on giving twenty-four hours' notice.

(*b*) Scotland

In Scotland the procedure as to pauper patients is the same as applied to private ones. The documents required are two medical certificates, a 'statement,' a

petition to the Sheriff, and an order by him. The two medical men must have seen the patient on the day on which they certify. The date of the petition must be within fourteen days of the dates of the medical certificates, and the patient must be admitted within fourteen days of the date of the reception order. Urgent cases can be detained in an asylum for a period not exceeding three days on a medical certificate of emergency, accompanied by the request of a relative or friend, pending the signing of the order by the Sheriff.

In Scotland a patient can be treated, with a view to cure, anywhere out of an asylum for six months without formal certificates if a medical recommendation to that effect and intimation are sent to the Commissioners of Lunacy. This is found to work well. Bills have been from time to time introduced into both our Houses of Parliament providing for a similar treatment of cases of incipient insanity in England, but have been withdrawn for lack of time.

In those cases where a lunatic is detained in a private house for more than a year for profit, an order from the Sheriff or the Lunacy Board is required. In the case of a pauper the inspector of the poor applies for the order, and here only one medical certificate is required.

(*c*) Ireland

For private patients two medical certificates, a 'statement,' and an order signed by a person who may or may not be a relative of the patient are required. If a patient has been admitted on one medical certificate only, another one must be obtained not later than within fourteen days of the first. The medical certificates must be dated on the day the patient is examined. If in the district asylums there be more accommodation than is required

for the pauper or destitute patients, paying patients may be admitted without being made paupers. For admission there are required two medical certificates, a declaration made before a magistrate by a relative or friend, a statement of particulars, and an agreement for payment. Pauper patients are generally sent to asylums on the order of two magistrates sitting together. Only one medical certificate is necessary, and this must be made by a dispensary medical officer and accompanied by a 'statement' filled up and signed by him. This 'statement' describes the 'species of insanity,' the 'probable cause of derangement,' and the 'prominent symptoms.' Another 'statement' having reference to age, occupation, residence, and so forth, has to be filled up by the relatives, or, failing them, by the police.

Destitute patients in whose cases there is no urgency can be admitted on the certificate of any registered practitioner, supported by a declaration made by a private individual before a magistrate, a 'statement' by relatives, a certificate of a magistrate, clergyman, or Poor Law guardian, and an agreement for removal on recovery.

PART II

THE VARIOUS FORMS OF INSANITY:

THEIR DIAGNOSIS, PROGNOSIS, AND TREATMENT

In this section I propose to deal with the several forms of insanity with regard to their differential diagnosis and their prognosis. Remarks on treatment will be given when deemed necessary, but this question rarely arises in general practice, except with a view to guiding the case for a few hours or days pending removal under certificate.

There have been many classifications of insanity; indeed, almost every writer on the subject has promulgated his own views. It has been classified according to its causes, its symptoms, its pathology, its psychology, taken either singly or in combination. The best method is that adopted by the Royal College of Physicians of London. For the purposes of this book I think it will be sufficent to enumerate the types of insanity most likely to be met with by my readers, followed by a discussion of the more important special forms without embarking upon the vexed question of classification.

1. TYPES OF INSANITY

1. Mania.
2. Melancholia.
3. Delusional insanity or paranoia.
4. General paralysis.
5. Dementia, including stuporous insanity.
6. Idiocy, imbecility, cretinism.

In addition to the above, there will have to be considered such special forms as puerperal, epileptic, syphilitic, alcoholic, adolescent, rheumatic and gouty, plumbic and climacteric insanities. Also circular insanity, moral insanity and borderland states, feigned insanity and 'police-court' insanity.

The great bulk—say three-fourths of the admissions of recent cases to asylums—are examples of mania or melancholia, the latter predominating at the present day; and, indeed, almost every case of insanity can be assigned to either the maniacal or the melancholic type, which have been spoken of as the pure or primary psychoses.

1. Mania

ACUTE DELIRIOUS MANIA OR ACUTE DELIRIUM—ACUTE MANIA—SUBACUTE OR HYPOMANIA—CHRONIC MANIA

Acute Delirious Mania or Acute Delirium

(*Délire Aigu*)

SYMPTOMS.—This grave mental disease is fortunately not common. The onset is sudden, and may follow a shock or some febrile disease. Extreme restlessness and sleeplessness are marked features. Hallucinations of sight are usual, together with delusions of a terrifying

character. Muscular tremors are marked. The temperature is raised, and may be as high as 103° to 104° F. In cases associated with influenza it may go to 105° or 106° F. The tongue, furred at first, soon becomes dry and black, and sordes form on the teeth and lips. Food is refused. The bowels are constipated, and when moved the evacuations are involuntary. Bedsores soon form and emaciation is rapid. Homicidal and suicidal tendencies are rare.

DIAGNOSIS.—Acute delirious mania or acute delirium may be distinguished from acute mania by its sudden invasion, high temperature, black tongue and sordes, and by its dreadful and horrifying delusions; from delirium tremens by the general gravity of its physical symptoms, its raised temperature, and by the absence of the characteristic hallucinations of sight, such as imaginary beetles, rats, snakes, and so forth, invariably met with in the alcoholic condition; from meningitis by the absence of photophobia and of vomiting.

PROGNOSIS.—This is bad, the patient commonly sinking into a typhoid condition and dying in a few days. He may, however, pass into a state of permanent weak-mindedness. Recoveries have taken place, but are extremely rare.

TREATMENT can only be properly carried out in an asylum, requiring, as it usually does, forcible feeding, a padded room, frequent use of hot baths, and most careful attention and watchfulness.

Example.—On June 30, 1902, I saw T. W. L., male, aged thirty-eight, who lived at Herne Hill, but was found wandering in London. His wife had died three days before, and he immediately afterwards seemed to become wild and strange, and the same day was missing from home. His proceedings during these three days were

never accounted for. When I saw him he was in a state of tremulous collapse, and was slightly jaundiced. He had a busy delirium, in which he talked incessantly, but could give no account of himself, and did not realize where he was nor whence he had come. He could only say that he had been travelling, and that there was someone always behind him. He was fortunately quite oblivious of his bereavement. He became weaker and weaker, and after another three days died of exhaustion, with some hypostatic pneumonia.

Acute Mania

Symptoms.—In a typical case the premonitory stage may be brief and difficult to recognise, but it is rarely altogether absent. It usually takes the form of restlessness and slight depression, lasting for a few days, and accompanied by insomnia and constipation. Often, however, these symptoms escape observation, and the patient seems to become suddenly and violently insane. He is restless, noisy, sleepless, and rarely still for two moments together. The emotional excitement is hilarious and optimistic rather than otherwise, but may be alternated with maudlin intervals. The delusions change so from moment to moment that they seem to chase one another through the patient's brain. He may be momentarily violent and aggressive, but his assaults on those around him are unpremeditated and are forgotten as soon as delivered. The moral inhibitory force is diminished or entirely lost, and indecent behaviour and profane talk are common, and are especially distressing to the friends in the cases of refined ladies, where it is often a matter of wonderment even to the skilled and case-hardened alienist where they can possibly have heard and in what way they can have stored in their brains the awful obscenities

which they pour forth. It is kind to explain to the relatives that this tendency to lewd and filthy talk is a well-recognised symptom of acute mania. Illusions are usual, and the patient commonly mistakes the identity of those about him; thus, he will confuse his doctor with some friend long since dead, or his nurse with his mother or other relation, but will rarely evince hallucinations. The conjunctivæ are injected, and the face generally flushed. The sense of muscular fatigue is quite wanting, and the restless excitement may be kept up for days and nights together. The tongue is furred and flabby; bowels confined; the skin is moist and the perspiration offensive; urine is scanty and high-coloured, and contains excess of urates and phosphates. The temperature is not usually increased, and may be subnormal. The habits may be wet and dirty, not from any want of control over the sphincters, but from sheer inattention. The hair is harsh and stiff, and has lost its natural gloss.

Diagnosis.—Acute mania may be distinguished from acute delirium and from delirium tremens as already described; from the maniacal form of general paralysis by absence of the fine fibrillary tremors, the defective articulation, and the grandiose delusions of that disease. Tremors are common enough in acute mania, but they are of a coarser and more jerky nature than those of general paralysis.

Prognosis.—This in early single attacks is good, but as the attacks multiply it becomes less favourable. The patient may get well in a few days, weeks, or months, or the disease may assume an intermittent form, or it may terminate in chronic mania or dementia. Rarely, he may die of maniacal exhaustion, an ending which is looked upon in asylums as being something of an opprobrium to those who have had charge of the case.

TREATMENT.—Here, again, asylum treatment is the only proper course. It will be best to proceed by urgency order, and it may be necessary to obtain two or even three trained attendants to be with the patient until his removal. The main objects in treatment are to sustain the patient's strength and to obtain sleep. Forcible feeding is rarely necessary, as well-applied, gentle persuasion by skilled attendants will usually induce the patient to swallow a sufficiency of slop diet. Sleep is best obtained by warm baths combined with cold affusion to the head. The use of sedatives or 'chemical restraint,' as it is called, is contra-indicated in acute mania, and there is an old asylum saying that he who gives narcotics to acute maniacs is likely to be a manufacturer of chronic maniacs. In cases where, pending removal to an asylum it is urgently necessary to procure rest, a judicious dose of chloral hydrate may prove useful, but in administering that drug it must be borne in mind that the tendency to death in acute mania is by heart failure. Morphia, either by mouth or hypodermically, or in any other way, is worse than useless. Hyoscine hydrobromate, in hypodermic doses of ℥i. to ℥ii. of the official injection, has been much lauded, but I have often been disappointed in its effects.

Example.—In June, 1902, I saw F. W., female, aged twenty-eight, of no occupation, but living at home with her father. There was no history of heredity, and no cause could be assigned for her attack of insanity, though probably some love trouble was at the bottom of it. Her father stated that for a day or two she had been wayward and strange: had wandered about the streets, and was known to have spoken to strangers under the impression that she knew them. She complained of being unable to sleep. Then she became almost suddenly noisy and

violent, used foul language, undressed herself, and threw all her clothes out of the window, and was a terror to all around her. When I saw her, three days after her first symptoms, she was wild and incoherent. She had stripped off and torn up every article of clothing, and was yelling at the top of her voice obscenities and filthy indecencies. (She was described by her friends as being naturally a rather religious and 'good-living' girl.) There was insomnia, and she required forcible feeding. She was placed under certificate, and I have since lost sight of the case.

Subacute Mania or Hypomania

This is less common than the acute form. It differs from it merely in degree, as its name implies. In its very mildest form little may be observable beyond some excitement, usually of an hilarious character, with restlessness, lack of sustained application to work, of good judgment, and of the higher inhibitions. The patient's self-consciousness is exaggerated, and his acts may be foolish or inconsistent. The more pronounced forms of hypomania approach nearly to the type of acute mania, though stopping short of the extreme insomnia, noisy motor excitement, and dirty habits.

Diagnosis.—In the mildest form this is often difficult, and the disease may easily be mistaken for brilliant eccentricity, with egotism and a lack of application; but in the more marked forms, where the standard of acute mania is more nearly approached, the diagnosis becomes correspondingly easy.

Prognosis and Treatment.—The mild form is often transient, and may get well without any treatment at all. It is, however, prone to recur, when it may assume a graver type. Rest, change of air and occupation, with

the bromides, are useful. Hypnotics and stimulants are best avoided, as in these patients a craving is easily established. In the more pronounced form the possibilities are in the main much the same as in acute mania, though the danger of death from exhaustion may be eliminated. A good many of these cases eventually drift into chronic mania. Asylum treatment is the only one likely to be beneficial.

Chronic Mania

Cases of chronic mania are not often seen outside the walls of an asylum, though occasionally one may come across a patient who has been discharged 'relieved' from an asylum, and whose friends, after clamouring loudly for his discharge ('release' they would call it), find him unmanageable, and want to get rid of him again.

Chronic mania is generally a sequel of the acute form, or it may supervene upon an attack of melancholia, or it may occur without passing through any acute stage at all.

Symptoms.—These are very various. The delusions may be numerous or few, the memory good or much impaired. There is generally some dementia present. Many of these patients are docile, and fairly industrious in a mechanical sort of way, giving little or no trouble so long as they remain under asylum discipline, but they are nearly all liable to outbreaks of maniacal violence at longer or shorter intervals, with little or no warning. A large number of them have auditory hallucinations. The term 'chronic mania' has been somewhat loosely applied to a good proportion of the rank and file of the chronic inmates of our asylums who work fairly well under supervision, but who would be incapable of earning a living outside. Many of these might, perhaps,

be more correctly classified under the heads of chronic delusional insanity or of dementia, but the symptoms of these chronic cases, where brain degeneration is present, often run so much into one another that a case which one alienist physician would call chronic mania might by another be placed, with equally good reason, under one of the other two heads.

Chronic mania can only be satisfactorily treated (or rather controlled and guided) in an asylum, and the prognosis is unfavourable.

2. Melancholia

SIMPLE MELANCHOLIA—MELANCHOLIA WITH DELUSIONS—AGITATED MELANCHOLIA—STUPOROUS MELANCHOLIA, OR MELANCHOLIA ATTONITA—CHRONIC MELANCHOLIA.

Melancholia is the most common of all mental disorders, and is also the most curable, the general recovery rate being said to be over 70 per cent. All the varieties of melancholia are gradual in onset, and present, as a rule, the period of alteration alluded to in a previous section. The chief forms are those above mentioned.

Simple Melancholia

In its mildest form this amounts merely to depression of spirits, with a sense of unworthiness, gloomy thoughts and forebodings of impending evil, and a generally jaundiced view of life and its worries, but there is no irrationality. It has been said that those who have suffered from a bad attack of 'the blues' have experienced a mild and fleeting form of simple melancholia. Nostalgia, or home-sickness, is also a form of this complaint, and has led to suicide. In the more severe form of simple

melancholia the symptoms just mentioned become more accentuated. The patient finds no pleasure in life; he sits and broods, is hopeless and listless. He sleeps badly, has disturbing dreams, and awakes after a few hours' broken rest in the depths of despondency. Such patients commonly have promptings to suicide, which they fight against, and they will sometimes ask to be sent to an asylum in order to be protected from themselves. A melancholiac's symptoms are most pronounced in the morning, and diminish as the day wears on. If suicide occur it is almost always in the morning hours. Refusal of food, constipation, and headache are also common symptoms. The circulation is sluggish, and the hands and feet are often cold and blue.

Diagnosis.—This presents no difficulties as a rule. The great question to determine is where ordinary depression of spirits ends and true melancholia begins. It is important to ascertain without asking leading questions whether the suicidal impulse is present, and if so to what extent, bearing in mind the axiom that every melancholiac is a potential suicide.

Prognosis.—In simple melancholia this is generally favourable, but recovery is slower than in cases of acute or subacute mania, taking months, perhaps, instead of weeks. Most recoveries take place, however, within a year. An improvement in the physical health is usually a prelude to mental improvement. The appetite reasserts itself, the patient sleeps better, and the morbid thoughts begin to disappear. The cases which do not improve usually drift into chronic melancholia. Death during simple melancholia is rare unless by suicide.

Treatment.—It is in these cases that most hope of recovery outside an asylum may be entertained. In the mildest type the patient will often recover with scarcely

any treatment at all, a short rest from work, with change of air and scene, regular meals and wholesome food, doing all that is required. An occasional dose of paraldehyde or chloralamid at night may be useful. In the more strongly marked cases treatment outside an asylum can only be carried out where the patient is well-to-do in life. If he be of limited means he had better be placed in an asylum. If the former course be adopted, he should be removed from his own home and surroundings, and from town if he be a town-dweller. Bearing in mind the possibility of suicide, he must never be left alone, especially in the early forenoon, on account of the proneness of these patients to attempt suicide in the morning hours. Therefore two trained attendants will be required, besides any member of his family who may elect to keep him company. The principal things to attend to are to give proper and sufficient food, to obtain sleep, and to relieve constipation. Much may be done by persuasion and system in inducing the patient to take food, and here it may be mentioned that in melancholia solid food and plenty of it is much more likely to benefit the patient than a slop diet, however nutritious and concentrated. A glass of stout at midday may help, and some spirit and water is often useful at night to induce sleep.

Obstinate refusal of food will often disappear after a few days' complete rest in bed, and such a rest will also greatly add to the patient's strength, paradoxical though this may appear. Should forcible feeding become necessary, the patient will do better in an asylum.

Sleep may be induced by warm baths and by a 'night-cap,' as mentioned above. In contradistinction from cases of mania, where they are injurious, some of the preparations of opium and morphia are often useful in melancholia. Experience has shown that opium does

not, as a rule, aggravate the constipation, as might be expected, and that the drug habit does not seem to get formed. The Turkish bath is also of great value. The use of the high-frequency electrical current has been suggested, and several cases of simple melancholia successfully treated in this way have come under my notice. In one, a month's application of the current for half an hour every other day was followed by complete cessation of the mental symptoms. In another, an overworked member of one of the learned professions suffered from a typical attack of simple melancholia, marked by general depression, hopelessness, and inability to concentrate his mind on his very onerous work. His symptoms disappeared within a fortnight, and he was completely cured by the current. Dr. David Walsh, under whose treatment the first patient was placed, informs me that the method is not only painless and safe, as is well known, but it imparts also a sensation of pleasure and exhilaration. The action on the body appears to be complex. Various conditions, such as bodily temperature, excretion, appetite, and the formation of white corpuscles, are modified by the high-frequency current. So far as simple melancholia is concerned, this form of treatment is specially useful, inasmuch as it relieves discomfort, induces sleep, and improves the general bodily condition in a marked manner, to say nothing of its moral effect upon the patient. It would, however, be contra-indicated in cases where he evinces any tendency to delusions bearing on the subject of electricity.

Constipation is best treated by the use of wholemeal bread, with vegetable and fruit in the dietary, if the patient can be induced to take solid food, and by a modicum of malt liquor during the day. An enema is a

good way of beginning treatment. Cascara, castor oil, or a few grains of calomel are all useful. No drug should ever be administered surreptitiously—*i.e.*, mixed with the food or drink.

Example.—I was called to see a young gentleman, aged twenty-six, a member of a rather eccentric family, though no heredity of insanity or other grave neurosis could be traced. For several days he had been morose, sullen and melancholy, and had slept badly; he had neglected his occupation, and locked himself in his bedroom, where he sat and brooded; he gave no reason for all this, and threatened violence to those who ventured to approach him. When, after some difficulty, I obtained access to his room, I found him the picture of sulky misery. His bowels were confined and his tongue furred. I was fortunate enough to gain his confidence, and he informed me that he had had a passing liaison with a young lady, a friend of his sister. He was remorseful for this, and after brooding for a few days over his folly, he began to fancy that his sister had somehow been degraded by his action. He admitted the absurdity of this when reasoned with, but could not get it out of his head. I got him away a few miles into the country, where I visited him several times. I commenced treatment with a brisk purge, and as he was rather a large meat-eater, I put him on a diet in which fish, milk, and farinaceous food predominated. He had plenty of outdoor exercise, to which he took kindly, and came to London twice a week for a Turkish bath. He took some potassium bromide thrice daily, and a scruple of chloral at night. In a week he was apparently quite well, but at the end of a fortnight there was a slight relapse, which only lasted for a couple of days, and there has been no recurrence since.

Melancholia with Delusions

In this form of melancholia the gloom and despondency have become accentuated, and unmistakable delusions appear. These may be restricted to the patient's bodily sensations, or may apply to things outside the subject, or to his moral being and spiritual aspirations. Hallucinations of various kinds form the ground-work of these delusions. Those of hearing are most common, and are generally associated with delusions of suspicion. Next in order come those of sight, smell, and taste. Those of smell are of grave import, and commonly point to irreparable brain disease, very likely of alcoholic origin.

The delusions concerning the patient's bodily sensations generally have reference to the head, limbs, and viscera. He may have a fire in his abdomen; his bowels or his gullet may be obstructed; he may feel shocks from wires laid on all over the house, or his ears may be assailed with vituperations through imaginary telephones. It is surprising how readily these patients assimilate new discoveries in science to account for their hallucinatory troubles. Almost as soon as wireless telegraphy became an accomplished fact, a lady complained to me that she was being annoyed by abusive Marconigrams, while several patients have told me that their inmost thoughts are being made known by means of X rays. The telephone in its early days was naturally seized upon with avidity as a vehicle for melancholic delusions, and it continues to retain its popularity, as mentioned above.

The delusious outside the subject are often distressing. A mother may hear the screams of her children, who she thinks are being tortured and are calling to her for assistance.

But the most depressing delusions of all are those bearing on the patient's moral or spiritual welfare. He may think his soul is lost; that he himself is the Devil or Antichrist, or that he has committed the unpardonable sin. The latter idea is the *bête noire* of those who have the care of melancholiacs. Few of these patients quite grasp what the sin is, or is supposed to be, but each identifies it with some evil-doing of his own—real or supposititious—and the delusion of having committed it is a frequent cause of attempts at suicide. Masturbators are prone to identify their besetting vice with this unpardonable sin, and they become correspondingly hopeless and despairing.

DIAGNOSIS.—Melancholia with delusions can only be confused with delusional insanity of a melancholic type, but in the latter the delusions are more systematized, and the patient is able to argue and to give coherent and often plausible reasons for his false beliefs.

PROGNOSIS.—Here, again, this is as a rule favourable, though recovery may not take place for a much longer time than in the milder form. I have known recoveries take place after quite a number of years. Disappointing relapses may occur. The melancholia may assume a recurrent type, or more rarely may become chronic.

TREATMENT.—This can only be carried out in an asylum with any hope of success.

Example.—On June 18, 1902, I examined E. D., aged fifty-four, female, married. Her husband said that for a few weeks she had been dull and unlike herself, and that for one week she had been restless, sleepless, and unmanageable. She threatened to commit suicide, and drank some lotion with that intent; also tried to get possession of his razors. I found the patient plunged in melancholy, moaning, weeping, and clutching at her throat. She told me she was being strangled and that

she could not swallow (which was not the fact); that she was paralyzed all over; that she could not sleep because directly she dropped off a heavy weight fell on the floor and woke her up. There was no history of heredity or of intemperance. She was placed under certificate, and had not materially improved when I last heard of her.

Agitated Melancholia

In these cases the patient (most commonly a woman) is never still except when asleep; she paces the room wildly, or sits with her face buried in her hands, rocking her body to and fro, moaning, sobbing, and bewailing her unhappy lot. She tears her hair, bites her nails to the quick, or picks her skin until the blood comes and sores form. Hallucinations are not common in this form of melancholia, but the delusions are of a most distressing character. Her soul is lost. Hell is yawning for her. She has brought ruin upon herself and those dearest to her. Curiously enough, these patients often take their food very well, and they are not as a rule actively suicidal.

Diagnosis.—Agitated melancholia might conceivably be mistaken for acute delirium, but in the latter disease we should find high temperature, frequent pulse, flushed face, and delirium of a varied but not of a melancholic type.

Prognosis.—This is not so unfavourable as a first glance at the patient would suggest. A large number get well eventually, but sometimes only after years.

Treatment.—Here, again, this can only be carried out under asylum supervision.

Example.—On April 28, 1902, I saw I. F., aged thirty-one, female, single. She had been in hospital with pneumonia, but had made a good recovery, and while

in a convalescent home she became excited and noisy. I found her in an abject state of misery, wringing her hands, rocking her body, moaning, whining, and even screaming with apprehension. She said the police were after her for having told an untruth, and were trying to get through the window to her. She clutched wildly at the clothing of any passer-by, shouting 'Hold me tight! Save me!' She trembled all over with terror. She was removed to an asylum.

Stuporous Melancholia, or Melancholia Attonita

These patients are deeply depressed and quite silent, sitting in one position for hours, and taking no notice of their surroundings. They have no idea of doing anything for themselves, but have to be washed, dressed and undressed, led to the closet, and so forth. They will resist what is done for them, but not at all strenuously—a kind of passive resistance. They have to be fed, but they do not violently or determinedly refuse food. They sleep badly. Although they appear to be always in this stuporous condition, they will generally attempt suicide if they get a chance.

Diagnosis.—This condition can only be mistaken for stuporous insanity, but in the latter disease real stupor exists, and the patient makes not the faintest attempt at resistance when being fed, dressed or undressed.

Example.—J. C., aged thirty-six, female, married. Seen by me in the insane ward of a workhouse on June 2, 1902. She took no notice of her surroundings, but sat in one position with her head bent forward, gazing at the floor. She sometimes made queer gestures with her hands. She was sleepless; had to be dressed and undressed, led to her meals, and generally fed. She was resistant to some extent, but was not violent. She

maintained an absolute silence, and did not seem to notice what was going on around her, but before her removal from home she had, while unobserved for a few minutes, succeeded in secreting a pair of scissors, with which she had cropped her hair short. This was an instance of one of those cases of which I have spoken in a previous section where no delusions could be included in the certificate, and yet the facts indicating insanity were well marked and made a strong certificate.

Chronic Melancholia

This disease, like chronic mania, is rarely met with in general practice, its victims going to swell the floating population of our lunatic asylums. It is usually a sequence of one of the acuter forms, and may set in after repeated recoveries and relapses. Even in its developed form chronic melancholia presents its remissions and relapses, often at intervals of a year or two. When at his best the patient is fairly contented and happy, and will employ himself usefully. During his relapses he becomes restless and miserable, and perhaps suicidal. These cases would be more anxious charges to our asylum officers than they are were it not that their relapses are usually heralded by premonitory symptoms easily read by the skilled eye. I knew of one case, however, where, after nearly twenty years of quiet and orderly behaviour in an asylum, a chronic melancholiac succeeded in dividing his crico-thyroid membrane with a blunt and jagged table-knife he had got hold of in the vegetable-shed, where he had long been a steady and industrious worker.

All cases of chronic melancholia tend to ultimate weak-mindedness.

3. Delusional Insanity, or Paranoia, formerly known as Monomania

This is a chronic disease of degenerative type, usually characterized by fixed and systematized delusions. It is not preceded by either maniacal or melancholic symptoms, and is not necessarily accompanied by any failure of the reasoning faculties. The condition may vary from imbecility, on the one hand, to a high but perverted intellectuality on the other, and between these two extremes there are many varieties of the disease. Hallucinations are present in most cases, but are not essential. The memory is generally good. The patient's reasoning power for matters outside his delusions may be perfect. In most cases heredity of some kind can be traced, either of insanity or intemperance, or of some other neurosis, and it is important to search for the 'stigmata of degeneracy,' such as asymmetrical or malformed ears, narrow and vaulted or, more rarely, abnormally shallow and wide palate, asymmetry of head or face, clubfoot undescended testis, shallow orbits, and so on.

In the early stage of delusional insanity the patient is likely to be hypochondriacal and too introspective; he worries over his own morbid sensations, real or fancied, and dissects his own thoughts. He applies to himself casual remarks he hears in the streets, and is full of morbid doubts and fears. As a rule he is uncommunicative, rarely telling his troubles, but he broods and worries over them in secret. After this stage has lasted for a longer or a shorter time the delusions become fixed. These are generally of a disagreeable kind. The patient is persecuted by voices conducted to his ears by telephones, phonographs, or wireless telegraphy. People can read his thoughts. Paragraphs in the newspapers

refer to him. The pictures on the wall have hidden meanings. He may be haunted by detectives, Freemasons, or Roman Catholic priests. In addition to auditory hallucinations, those of smell and taste are not uncommon, and are generally of an unpleasant or offensive kind. Soon the patient becomes sullen and resentful; he casts about for the cause of his persecutions, and fixes upon someone or other as their author. Then he is a potential homicide, though many of these patients are capable of great self-control. This is the dangerous stage of delusional insanity. Later, delusions of grandeur are likely to develop. He may fancy he is a great admiral or general, the Messiah or the Deity, and may adorn his dress in some eccentric way to denote his position. During this stage mental weakness commonly becomes more marked, and the dangerous proclivities less so, the patient's conceit in his exalted position seeming to swallow up his resentful feelings against his supposed persecutors. This second stage may last for many years. The third and final stage is usually one of slowly increasing dementia.

Diagnosis.—In the expansive stage delusional insanity might be mistaken for general paralysis, were it not for the fixed nature of the delusions in the former, contrasting strongly with the ever-changing ones of the latter. Also, in general paralysis the memory is impaired, the reasoning power is conspicuous by its absence, and the physical signs are to be recognised. A paranoiac's symptoms may also be acutely maniacal or melancholic for transitory periods, but careful observation will not fail to detect the systematized delusions and the absence of incoherence.

Prognosis.—This is bad, the disease usually ending in dementia, but these patients often live to a great age.

Sometimes the disease seems to become arrested, and rarely some improvement takes place, but not often to a sufficient extent to warrant the patient being discharged to his friends. Recoveries are said to have occurred, but I have never been so fortunate as to meet with one.

TREATMENT.—Confinement in an asylum affords the best protection to the patient himself and to the public, and also the best hope of an amelioration of the more acute symptoms. There can be no more dangerous lunatic at large than a paranoiac with fixed delusions of persecution. The main difficulty in the treatment of these cases is that in the early stage the patient is often so secretive and so capable of concealing his delusions that murder may be committed before insanity is diagnosed.

Example.—One of the best-marked cases of delusional insanity I have seen was that of a male patient, A. W., whom I knew for years in Hanwell Asylum. He inclined towards the imbecile type of the disease. On admission he called himself Lord W., and said he was the creator and ruler of the universe. If his claims were doubted by the other patients he became threatening and abusive. After a year or two he developed a delusion that one of the asylum inspectors had changed heads with him, and he would bestow most foul abuse on this officer. It was ludicrous to be appealed to in such terms as these:

'Look at that villain! He has stolen my holy head! How can you expect me to rule the universe with this beastly thing he has stuck on my shoulders? Oh, you thieving ruffian!'

He was strongly homicidal towards this inspector, and constantly threatened him. In the course of years the inspector died, and after his death A. W.'s delusion about the theft of the holy head gradually became less

apparent. When last I heard of this patient he was still a pronounced paranoiac with systematized delusions, the principal one then being that his intestines were being cut out every night.

4. General Paralysis, General Paresis, Dementia Paralytica.

This terrible and fatal malady is a disease of the prime of life, and has cut short some of the brightest and the best intellects. It was first recognised as a distinct form of insanity by French physicians about ninety years ago. Now it is one of the best known and most easily recognised of all mental diseases. It was noticed quite early that its most usual victims were powerful, hearty men, who had lived hard and never ailed; who had boasted of their ability to see the clock round; who had been able to drink freely without doing matutinal penance; in short, men who had 'burnt the candle at both ends,' and had led irregular if not debauched lives. It used to be rare in women, but is now becoming commoner; at the present time it is three times more frequent in men than in women. It usually manifests itself between the ages of thirty-five and fifty-five, and though attacks have been reported between the ages of sixty and seventy, they have probably been generally cases of senile brain changes, which often closely resemble general paralysis in tremors and exalted notions. In recent years some cases have been recognised in childhood and early adolescence, and these have always been traced to inherited syphilis.

For many years the principal causes of general paralysis were said to be sexual excess; long hours of work (or play), with insufficient sleep; alcoholism and syphilis. Plumbism and excessive meat diet had also been spoken

of as causes, as also had trauma and influenza. Syphilis as a cause has overshadowed all the others in the opinion of the best authorities in more recent years, and so convinced was Fournier of this that in 1894 he introduced the term 'parasyphilis' in speaking of general paralysis and of tabes dorsalis.

Schaudinn discovered the pale spirochæte in 1905; Wassermann published his test in 1907. Ehrlich gave us his remedy in 1909. A flood of new light was then thrown upon the etiology, pathology, and treatment of general paralysis and tabes. It was soon found that in practically every case of the former disease a positive Wassermann reaction could be obtained in the cerebro-spinal fluid or in the blood. Noguchi found the pale spirochæte in the brains of twelve cases of 'G. P.' out of seventy examined. These two facts led to the suspicion that general paralysis is an actively syphilitic disease, and that the term 'parasyphilis' is something of a misnomer.

It has long been recognised that a very small proportion of syphilitics ever become paretic or tabetic. Mott puts the figures as 3 to 4 per cent. Therefore it has been concluded that some other factors must be at work to produce these diseases, and they have been thought to be, in order, sexual excess, alcoholism, traumatic injury, and, as regards moral causes, worry and mental anxiety. (Mott, however, has pointed out that in juvenile general paralysis all these causes can be excluded.) Sunstroke has been spoken of by several authors as a possible physical cause, but this usually occurs among our soldiers in tropical climates, where syphilis also is unfortunately only too common.

A common argument in favour of the origin of general paralysis not being necessarily syphilitic was the un-

doubted fact, recognised by all asylum medical officers, that among the admissions of general paralytics to our asylums the external evidences of former syphilis are comparatively rarely to be found; but this fact may cut both ways. The probability is that in certain cases of syphilis the early symptoms—cutaneous, lingual, faucial, and ocular—have been so slight as to attract little or no attention. In such cases prompt mercurial treatment has probably been carried out only perfunctorily or not at all, the natural result being that the more highly organized structures have later become involved. This seems to be a likely explanation of the apparent paradox. In proved syphilitic general paralysis there is a considerable interval between infection and the appearance of the paralytic symptoms. The average interval is said to be about ten to fifteen years. Anti-syphilitic remedies are apparently of no avail when paralytic symptoms have set in. Krafft-Ebing has stated that general paralytics are insensible to the inoculation of syphilitic virus; but this statement would seem to require further confirmation. I myself hold the strong opinion that, granting syphilis to be the prime cause, sexual excess, alcoholism, and mental strain are the most frequent of the subsidiary causes of general paralysis. It is well recognised among asylum officials that the wives of many general paralytics are handsome and attractive women of an erotic type, and it is quite common to speak of such a one as a typical 'G. P.'s' wife.

General paralysis has been divided by the late Dr. Blandford in his lectures into three stages—viz., alteration, alienation, and progressive paralysis and dementia. During the period of alteration many of the phenomena are physical rather than psychical. One of the commonest is a difficulty or hesitation in speech, especially

when pronouncing the labials; besides this, fibrillary tremors of the lips, tongue, and facial muscles may be present. The pupils may be unequal in size or irregular in outline, and there may also be a complete absence of light or convergence reflex. The handwriting may alter for the worse, and letters, especially terminal letters, may be dropped in writing. The knee-jerks are probably exaggerated, but they may be sluggish or absent altogether. The face may now or later on exhibit a greasy appearance, the gait become uncertain, and the patient liable to occasional attacks of 'faintness,' which are really early manifestations of the convulsions peculiar to general paralysis, and known as congestive attacks. Occasionally a convulsion may be the earliest symptom in commencing general paralysis, and these cases usually run a rapid course downhill. In such a case the diagnosis is often difficult, especially where the patient already has albuminuria, as the convulsion may easily be taken for a uræmic one. I shall presently give an example of one of these puzzling cases.

Other early signs are an undue elation and optimistic tendency, forgetfulness, neglect of business, restlessness at night, with drowsiness in the daytime, especially after meals. Failure to recognise mental irresponsibility in early general paralysis is not unknown in our criminal courts, a fact that demands the careful attention of the friends and legal advisers of persons charged with criminal acts inexplicable on ordinary grounds. To the skilled observer a little stumble in the speech or an irregular pupil may at once reveal a successful line of defence.

When the period of alienation sets in, the above-named symptoms all become more accentuated; the defective articulation deteriorates still further, and such

words as 'artillery' and 'Biblical criticism' cannot be negotiated satisfactorily; the enhanced difficulty of pronouncing the labials makes the patient appear as though about to burst into tears; the gait becomes still shakier; the tongue, in addition to the fibrillary tremors, becomes jerky on protrusion or withdrawal; the handwriting alters still more, and there is, in fact, general muscular inco-ordination. The pupillary symptoms are still in evidence; and it may here be mentioned that in general paralysis they are usually the only ocular symptoms present, changes in the optic discs being rare, as also are strabismus, nystagmus, and ptosis. In this stage of alienation maniacal excitement is a usual system, though cases of a melancholic type are by no means uncommon. Also the folds and furrows in the face may partially disappear, giving the features a smoothed-out appearance. The patient is restless, hilarious, and full of grand delusions, which vary from hour to hour, and even from minute to minute. He is a duke, a king, an emperor. One 'G. P.' I knew was going to build a bridge across to America and run solid gold locomotives along it. The general paralytic's house is a marble palace; he is going to give his doctor a thousand gold watches and the doctor's wife a pailful of pearls; he can lift a ton, or can run a hundred miles without stopping. (In women patients the megalomania often takes the form of exaggerated notions of their own personal charms.) The appetite now commonly becomes voracious. Sexual desire is generally increased, though the power of fulfilment may be lacking. By the way, it is always well to remember that sexual excess may be a symptom of general paralysis as well as one of the presumed causes.

In this stage of alienation the patient may squander

money on useless articles. He may also indecently expose himself or attempt to take liberties with the female servants. If thwarted in any of his absurd proceedings, he may become violent, though only temporarily so as a rule, he not possessing the necessary determination or concentration of purpose to carry out any definite act of aggression. Pilfering is a very common symptom. Congestive attacks are now generally more frequent than ever. In these the convulsions are not so severe as in true epilepsy, and the patient rarely bites his tongue; but each seizure leaves him more enfeebled, both mentally and physically, than did the last. More or less aphasia may also be left after the convulsions. The patient is very emotional, and is prone to tears or laughter on slight provocation. Remissions may now take place. Sometimes he seems quite recovered, but he always relapses. I was once acquainted with a general paralytic who was thrice discharged from an asylum as recovered, each time to return relapsed after having rendered his wife pregnant again—a truly awful state of things. During the stage of alienation the type of the disease may change from lively and talkative elation to depression and melancholia, or the reverse may take place. This condition is known as general paralysis of the double form.

The general nutrition of the patient often tends towards corpulence, but when this becomes marked congestive attacks commonly supervene. In asylums a steady increase of weight in a general paralytic is usually looked upon as a precursor of convulsions, and these always leave the patient thinner and more paralyzed than he was before, as mentioned above.

In the third stage the patient loses flesh and becomes more demented. Congestive attacks continue. Mastica-

tion becomes imperfect and swallowing difficult. The bones also become brittle and prone to fracture on very slight strain. Soon he has to keep his bed through sheer debility; bedsores may form in spite of every care. Continual grinding of the teeth is an unpleasant symptom, and these often get worn down nearly to the gums. He is now noisy, destructive, wet, and dirty; but the appetite remains good, and he may choke himself in eating if not closely watched.

Death mostly occurs from asthenia, often accompanied by hypostatic pneumonia, or from a succession of congestive attacks, with raised temperature, cyanosis, and profuse sweating.

I have endeavoured above to give a sketch of a typical case of general paralysis, but there are many which run a very different course from this hypothetical one. It has been already mentioned that cases of a melancholic type are not uncommon, in which the flamboyant joviality of the average 'G. P.' is replaced by a settled melancholy, and in these cases suicidal impulses, though rare as a rule in general paralysis, are by no means unknown. I call to mind the sad case of a medical man who diagnosed the onset of his own fatal disease, and who became acutely melancholic and suicidal until the final dementia set in. There was never in this case, from its onset to its end, any trace of megalomania.

In other cases the dementia may occur so early in the disease, and may make such rapid strides, that the emotional symptoms are hardly seen at all.

General paralysis without apparent symptoms of insanity has been described, and I have seen one such case in an early stage in Guy's Hospital. The physical symptoms were well marked, but one could find no mental symptoms of any kind, not even loss of memory.

There is now no doubt that general paralysis may in rare cases develop itself without mental symptoms, but these are sure to occur before the end.

General paralysis may supervene upon ataxy of quite considerable duration, or may be of an ataxic type throughout.

In juvenile general paralysis many of the patients have been noticed to be mentally weak long before the paralytic symptoms become developed. Congestive attacks and grand delusions are rare. Clinical symptoms of inherited syphilis are commonly present.

Glycosuria is more usual in general paralysis than in other forms of mental disorder.

DIAGNOSIS.—General paralysis can be distinguished from acute mania by its slower development, its grand, varying and flexible delusions, its slurring speech, its fibrillary tremors of the tongue and lips, and its pupillary irregularity or inequality. In its depressive form it might perhaps be mistaken for melancholia, but here, again, the physical symptoms will usually clear up the diagnosis.

PROGNOSIS.—This is always bad, though the duration of the disease varies greatly. It may last from one to four or five years, or in well-to-do patients who can command every comfort and care, much longer. It sometimes seems as though the educated brain yields more slowly than that of, say, the daily labourer to the inroads of general paralysis, and I know of one case in an educated and accomplished gentleman which lasted more than twelve years. The average duration, however, of general paralysis, from its first appearance, is two years, or very little more.

TREATMENT.—This can only be carried out in an asylum, and resolves itself into watchful care, cleanliness,

and good feeding with soft substances not likely to produce asphyxia—mincemeat and so forth. Many a general paralytic has been choked by cramming into his mouth a potato or a lump of meat stolen from a fellow patient's plate. Their pilfering propensities are only equalled by their voracious appetite. A few years ago some promising results were reported in cases of undoubted syphilitic origin from the so-called intensive mercurial treatment of the French school, either by inunction or by the hypodermic injection of mercuric benzoate in normal salt solution—$\frac{1}{2}$ grain, cautiously increased to $\frac{3}{4}$ grain, once a day; but the treatment has lately been abandoned, I believe, probably through the advent of salvarsan. In 1902 Dr. Ford Robertson, pathologist to the Scottish asylums, and his colleagues commenced special investigations into the pathology of general paralysis and tabes dorsalis. They discovered that bacilli of the diphtheroid group could be found to be invading the tissues in all cases of advancing general paralysis and tabes dorsalis, and they formed the opinion that the chief seats of invasion were the naso-pharyngeal and oral mucosæ in general paralysis, and the genito-urinary tract in tabes. They also found these bacilli in the cerebro-spinal fluid removed by lumbar puncture and in the brain post mortem of general paralytics. They ascertained that two species of these diphtheroid bacilli, which they named *Bacillus paralyticans longus* and *Bacillus paralyticans brevis*, were often virulent to mice and rats, some of which showed after death the brain changes characteristic of general paralysis. Dr. Robertson contends that the essentially syphilitic origin of general paralysis has never been proved, but he admits that syphilis strongly predisposes towards the subsequent development of this disease. An antiserum was prepared

in the sheep, which in one case of general paralysis gave great though only temporary improvement, but it was more successful in tabes dorsalis. Writing, however, in 1912, Dr. Robertson says that in general paralysis the most he can claim is that in a few cases there has been some retardation of the rate of progress of the malady. Drug-treatment of every description has long been abandoned as useless in the so-called parasyphilitic diseases, though it has been recently said that congestive attacks may be staved off by 10 grains of urotropine thrice daily. In 1900 intrathecal injections of mercury into the spinal canal were first tried, but with disappointing results. Later on, salvarsan, both by intramuscular and intravenous administration, proved a failure, and this was thought to be due to the fact of the choroid plexus shutting the remedy out from the cerebro-spinal fluid. More recently still certain preparations of salvarsanized serum have been injected into the spinal canal, and though in tabes improvement has often occurred, lightning pains have diminished, and the Wassermann reaction has become negative, yet in general paralysis no lasting improvement has yet been recorded, and the disease still remains incurable so far as our present knowledge goes.

Example I.: A Typical Case of General Paralysis.—I saw H. A., aged forty-two, married, hotel broker, in February, 1903. He had lived an intemperate and careless life, and had been an unfaithful husband. Had earned money easily, and spent it at gambling clubs and in debauchery, rarely having more than four or five hours' sleep a night for several years past. There was a strong suspicion of syphilis of about five years' standing, but there had certainly been no systematic treatment of the complaint. His wife had six living children, who were said to be

healthy, but I did not see them. She had had six miscarriages during the last five years, but the penultimate pregnancy went on to term, and the child was then alive and apparently healthy.

When I saw the patient he was very wild, excited, and threatening, having just before had a struggle with the police. He was emotional, crying and laughing alternately. After a short conversation his excitement began to subside, and his megalomania became more apparent. He asked me to dine with him at the Hotel Cecil, and when I declined he said he would give *carte blanche* there for me to give a series of balls to royalty, and he would bear the expense. He said he would buy me as many gold watches as ever I liked ; also, that he had a message for me from the King. The physical symptoms of general paralysis were then very slight. He was removed to an asylum, where at first he gave a great deal of trouble from his noisy and boisterous behaviour. In the course of some weeks he had several slight congestive attacks, and fell into a dull and demented condition, with occasionally dirty habits. The tremors of general paralysis became very apparent and his gait much enfeebled. I ultimately lost touch with this case, which doubtless followed the usual downward course.

Example II. : A Case commencing with a Convulsion and running a Rapidly Fatal Course—a Mistaken Diagnosis.— In December, 1903, I was sent for in a hurry to see a gentleman, aged forty-two, with whom I was slightly acquainted, but of whose previous history or habits I could learn nothing. He had up to that day been in what seemed to be perfect health, and was then the head of a large and successful business. He was said to have just had a 'fit' in his office. When I saw him he was semi-conscious, evidently recovering from an epileptiform

seizure, in which he had *not* bitten his tongue. The next day two similar attacks of convulsions took place. I found there was marked albuminuria, and also some diffuse retinitis. There were no mental symptoms beyond some hebetude after the fits, and no physical symptoms of general paralysis. Former syphilis was strenuously denied, and I could find no traces of it. There was undoubted arterio-sclerosis present. I looked upon the case as uræmic in nature, and treated it accordingly. In the course of a few weeks the albumin had almost disappeared, the patient expressed himself as feeling very well, and he returned to his business; but his manager told me that he did not seem to grasp commercial matters as readily as he had formerly done. In June, 1904, he decided to take a complete rest from work and go for a trip to New Zealand, a friend accompanying him. On joining the liner he had one fit, the first for six months. During his absence from England I was able to ascertain some particulars as to his former habits which I had not known before. He had been given for years to great excess in sexual matters; had commonly remained at his club (a sporting one) until the small hours of the morning, often having not more than four hours in bed; and had consumed a good amount of alcohol during his visits to his club, though he was in nowise a confirmed alcoholic.

I now began to suspect a paretic origin for his illness, I saw him again in October, on his return to England. He had had two severe fits in succession on his voyage out, and two similar ones while in New Zealand. He returned to his business temporarily, having decided to turn it into a limited liability company, owing to his proneness to fits at uncertain intervals, and this determination involved a certain amount of mental strain. On October 22 he had been engaged for some hours with

his solicitor, and had been bright and intelligent. On the following day he had ten severe convulsions in succession, and after these undoubted symptoms of general paralysis manifested themselves—tremors, slurring speech, and a smiling contentedness. His sight now began to fail. He died a month later, after another succession of fits. He never had any delusions, was never noisy nor violent, and never gave any trouble worth mentioning. He was treated at his home throughout, with the aid of two male nurses. The whole duration of his illness, from the morning when he had been busily engaged in his work to his death, was only eleven months and ten days.

Example III.: A Case in which Untreated Syphilis appeared to be the Exciting Cause.—A gentleman without hereditary taint of any kind had lived an irregular life from his youth, drank a good deal, kept late hours, and was a slave to sexual excess. As a boy he had been a masturbator. At the age of thirty-two he contracted syphilis, and was well advanced in the secondary stage before he had any advice at all, when he consulted me. I soon found he was absolutely unable to take mercury in any form. Many preparations were tried, with invariable failure; he became salivated within a day or two, and within a week he was quite melancholic and refused to go on with the treatment. As a poor alternative I tried all the iodic preparations in turn, and with much the same unsatisfactory result; he became iodized and depressed. Salvarsan was in those days unknown. In the end he neglected treatment altogether, and in due course his earlier and more urgent symptoms disappeared, and he seemed to be in fair health, but did not mend his ways of life. Here I temporarily lost sight of the case, but eight years afterwards I came across his path again. He had begun to

neglect his profession, he became boastful and optimistic, and the physical symptoms of general paralysis were now apparent. Soon after this he left his home for no known reason, and was found in Paris, detained by the police as a wandering lunatic. On his return to England he was placed under certificate, and died in a private asylum three years later of general paralysis. This case, again, was one of those slow ones which I have alluded to on page 63 as occasionally occuring in the highly educated brain. There was one quite long remission.

5. Dementia

It was usual, until comparatively recently, to divide the dementias into acute, chronic, and senile. The first of these divisions, however, which had also been named acute primary dementia, is now by most authors not looked upon as a dementia at all, but is spoken of as stuporous insanity. Savage and Goodall divide dementias into primary and secondary. They point out that in the latter there is destruction, more or less, of the mind, which can never be recovered from, while in the former there is generally mere functional arrest, which may pass off.

I propose for convenience in this little book to keep to the old divisions of acute, chronic, and senile dementia, but to deal with the acute form under its proper name of stuporous insanity.

Stuporous Insanity, formerly known as Acute Dementia and Acute Primary Dementia

This disease attacks young people, generally from fifteen to twenty-five years of age, and is often due to some shock or fright, which seems to paralyze the patient's mind. It has been known to ensue even upon

joyous news. It may follow child-bed, acute febrile diseases, surgical shock, or loss of blood. Any exhaustive influence may be a cause, such as phthisis or masturbation. Hereditary predisposition to insanity is commonly present.

Symptoms.—The onset is usually sudden, though there is sometimes an antecedent acute hallucinatory delirium. The patient seems to be deprived of all volition and feeling. He is utterly apathetic. He will stand or sit for hours together staring blankly before him, expressionless, or with a vacant, puzzled look; but sometimes automatic movements take place, such as wagging the head or moving an arm or a leg continuously. Very occasionally there is some cataleptic muscular rigidity. The circulation is feeble and the extremities are often blue. Chilblains are usual. There is often refusal of food. The habits may be wet and dirty. He may, perhaps, sleep very well.

Diagnosis.—This disease can only be confounded with melancholy with stupor, and the differences have already been given under that heading (p. 51).

Prognosis.—The patient recovers completely, or recovers 'with defect,' or may become chronically demented. As a rule the chances of recovery are in direct ratio to the suddenness of the seizure. A great many cases get perfectly well. Death has sometimes occurred after a few days from collapse.

Treatment.—This is best carried out in an asylum, though many cases have been successfully treated at home. The main indications are to restore nutrition and to secure rest. Rest in bed is essential, unless the patient be so excited as to render this impossible. Warmth is very important. Treatment is well commenced by an enema, as the rectum is commonly loaded.

Forcible feeding may be necessary, but the patient is usually amenable to tactful attempts to make him take food, properly persevered in. Chloralamid is useful in inducing sleep. During recovery, iron, quinine, arsenic, and strychnine are likely to be beneficial. Static electricity has been used with advantage.

Chronic Dementia

This may supervene upon any acute form of insanity, for which reason it is often spoken of as secondary dementia. It may also succeed apoplexy, epilepsy, intemperance, fevers, pneumonia, or child-birth. A form is described as occurring in those who have had constitutional syphilis some years before. The most constant symptom in chronic dementia is loss of memory for recent events. The patient cannot recollect the names of his friends, the address at which he lives, the day, month, or year. He becomes careless of his appearance, slovenly and dirty. Delusions are generally present. He may neglect the calls of nature. In some cases there is a tendency to excitement, in others to depression, but in a great many neither is present. The bodily health may be pretty good, but the chances of life are less than those of the ordinary individual, and these patients easily fall victims to lung troubles.

Prognosis and Treatment.—The prognosis is unfavourable, most cases going from bad to worse in their mental state, but when chronic dementia follows febrile complaints it may be recovered from. The syphilitic form is often complicated with tumour of the brain. It may sometimes yield readily to iodides, but more often all treatment is disappointing. Most cases of chronic dementia have to be sent to asylums on account of excite-

ment and dirty habits, but the milder forms can be managed very well at home if proper skilled help be obtained. Treatment must be quite on general lines, the physician meeting symptoms and emergencies as they arise.

Senile Dementia

This disease is rare before the age of sixty-five, but sometimes belies its name by appearing quite early in the fifth decade, thus reminding us of the excellent aphorism that a man is as old as his arteries. It differs from chronic dementia in being a primary disease, having for its origin the degenerative lesions of old, or rather worn-out, tissues, and not being the sequel of any acute insanity. The onset is, as a rule, gradual, but sometimes is marked by a passing maniacal outbreak. The developed symptoms differ little from those described under chronic dementia. A few of these patients have grand and expansive ideas, in addition to the typical loss of memory, and in some there is a proneness to indecent talk and actions. Maniacal attacks may occur in the course of the disease, or there may be melancholic intervals. On account of these, and of the tendency to lewd behaviour, it is generally best to place these patients under asylum treatment, though some, especially demented old ladies, can be managed very well under private care.

Hereditary predisposition can often be traced in cases of senile insanity. Clouston places the proportion at 13 per cent. if collateral transmissions are counted, while Bevan Lewis has traced it in 22 per cent. of his cases, also counting collaterals.

It is not always easy to diagnose a case of senile dementia occurring before the age of sixty from general

paralysis: the inflated ideas and optimistic restlessness may be present in both diseases. There may also be some muscular tremor in senile dementia. The physician will have to be guided by the history of the case, and by the presence or otherwise of the physical symptoms of general paralysis—fibrillary tremors of tongue and lips, pupillary abnormalities, and clipping of words.

6. Idiocy, Imbecility, Cretinism

Idiocy

Idiocy may be congenital, or may have been caused in early infancy by convulsions. In the true idiot there is an entire absence of the intellectual and moral faculties. He is without ideas of any kind, is incapable of being instructed, and unable to reason. He sits or lies about and slobbers, and what movements he makes are automatic. He is generally unable to walk or talk. Some idiots a little higher in the mental scale may be taught to observe some of the decencies of life, may learn to speak a few words, and to recognise those who look after them, but this is about their limit. The stigmata of degeneration mentioned on p. 53 are often apparent. The head may be microcephalic, hydrocephalic, or distorted; the genital organs in the male hypertrophied or imperfectly developed.

The Royal Commission on the Care and Control of the Feeble-Minded has defined 'idiots' as persons so deeply defective in mind from birth or from an early age that they are unable to guard themselves from common physical dangers, such as, in the case of young children, would prevent their parents from leaving them alone.

Idiocy presents no difficulties in diagnosis. The physical symptoms alone are unmistakable. Doubt may,

however, arise in infantile cases, where the parents are anxious for an opinion as to their child's future mental capacity. In such cases signs of idiocy are squint or nystagmus, inability to support the head, rhythmical movements, absence of smiling after the age of six months has been reached, and lateness in walking or talking.

Little can be done in the way of treatment. Idiots are best separated from healthy children. They may often be managed pretty well at home up to the age of puberty, but after this they will be better looked after in such an institution as Earlswood Asylum. Surgical treatment for the relief of pressure has been tried, on the hypothesis that premature ossification of the cranium has checked the development of the brain. The results have not justified the expectations.

Imbecility

Imbecility is a minor degree of brain defect than idiocy. Like the latter, it may be either congenital or due to hindered brain development during childhood. The term imbecility covers a wide field, having idiocy at one pole, and the condition known as moral insanity at the other, with numerous degrees of mental deficiency between these two.

The extreme width of this field is emphasized by the fact that the above-mentioned Royal Commission has given definitions of three different forms of imbecility in young persons, as under:

1. *Imbeciles.*—Persons who are capable of guarding themselves against common physical dangers, but who are incapable of earning their own living by reason of mental defect existing from birth or from an early age.

2. *Feeble-Minded.*—Persons who may be capable of

earning a living under favourable circumstances, but are incapable, from mental defect existing from birth or from an early age—

(*a*) Of competing on equal terms with their normal fellows, or

(*b*) Of managing themselves and their affairs with ordinary prudence.

3. *Moral Imbeciles.*—Persons who from an early age display some mental defect, coupled with strong vicious or criminal propensities, on which punishment has little or no deterrent effect.

Besides these classes, the Commission make others for epileptics, inebriates, and deaf-and-dumb or blind imbeciles.

Speaking generally, imbeciles are all more or less dull at learning, though some show much aptitude in special branches of knowledge, such as music or arithmetic. They may be affectionate and grateful, though liable to sudden attacks of passionate temper. In the lower types the stigmata of degeneration are commonly present. Many imbeciles are addicted to theft. Some are prone to incendiarism or homicide. Of such are the servant-maids who drown little children in ponds, or attempt to poison their mistresses by putting vermin-killer in the teapot or paraffin-oil in the soup.

In the milder cases, or semi-imbeciles, the patient may acquire some knowledge at school, but the intelligence stops short at that of a child. All imbeciles are morally deficient, as well as mentally so. Their sexual instincts are strong, and they are prone to masturbation, often at the same time exhibiting an exaggerated religious tendency, with a fondness for attending prayer and revival meetings and singing hymns. Some possess a certain

fund of shrewdness and humour, and from such as these were recruited the King's jesters in the olden days. The character of Wamba in 'Ivanhoe' is an excellent description of this type of imbecility.

The prognosis in imbecility is not favourable. Much improvement may take place under training and moral control, but recovery never. These patients may employ themselves usefully to a certain extent, but their untrustworthiness, their sexual proclivities, and destructive tendencies render them dangerous persons to be at large. It is often, however, difficult to certify them, and an imbecile may cause a vast amount of misery and disgrace in a family and yet never get under certificate.

The recently passed Mental Deficiency Act will probably make a huge difference in the treatment and prospects of many imbeciles.

Cretinism

This form of idiocy or imbecility is due to deficiency in the function of the thyroid gland, and is endemic in certain mountainous districts of the Continent of Europe. In this country the only cases likely to be seen are those of sporadic cretinism, or myxœdematous idiocy. It usually makes its appearance during the first year of life. The patient's growth is stunted; his features are flat and expressionless; the body and limbs are thick and short, the hair coarse, and the skin dry. The general aspect is repulsive. The thyroid gland is very small or absent altogether, but there are often fatty swellings over the clavicles. The temperature is generally subnormal. These patients are generally almost idiotic, but quiet and harmless as a rule.

It is in this form of mental deficiency only where the prognosis is at all hopeful, and where improvement may

follow medical treatment. If the administration of thyroid gland be begun quite early, physical improvement soon commences and growth advances. Later, a considerable degree of mental amelioration will follow. The early effects of the medicine must, of course, be carefully watched, and its administration be temporarily suspended if necessary. A good plan is to begin treatment with a 2-grain tabloid of dried thyroid twice a day. The course may have to be extended, with intermissions, over many years, or for the remainder of the patient's life. I know of a case in which a boy who was once quite idiotic became, at the age of twenty-two, able to earn his living as a shoeblack. The result does not read like a brilliant one, but to those who watched the improvement in the patient it has been thought satisfactory.

2. SPECIAL FORMS OF INSANITY

1. Puerperal Insanity, including the Insanity of Pregnancy and of Lactation

The Insanity of Pregnancy

This may occur in the earlier, but is more common in the later, months of pregnancy. It is less likely to occur in a first than in a subsequent pregnancy. In the earlier months the symptoms may be maniacal, or, more usually, melancholic. In many cases the patient has the delusion that poison is mixed with her food. If the insanity develop during the first three months of pregnancy, she often gets perfectly well after the fourth month with little or no treatment, but is liable to an attack of puerperal insanity after delivery. The induction of premature labour has been suggested in these

cases, but is not, in the opinion of the best authorities, a justifiable operation.

When insanity comes on in the later months of pregnancy the form is nearly always melancholic; delusions about poison are present, and the patient takes a dislike to her husband. Here the prognosis is less favourable. It sometimes happens that a temporary remission takes place during labour, the patient relapsing afterwards. Grief and worry are common causes, as also is any impairment of the physical health. Treatment can often be carried out at home, the indications being perfect quietude, with rest in bed, gentle laxatives, and occasional doses of trional, paraldehyde, or possibly chloral, to produce sleep. Should suicidal tendencies show themselves, an asylum offers the only alternative.

Puerperal Insanity

This is a form of mental disease likely to be met with in general practice. As a rule it causes a great amount of anxiety and responsibility to the medical attendant. It occurs most frequently in women hereditarily predisposed to insanity, and especially where the heredity is in the female line. Here it may be mentioned that sometimes a few days after labour there sets in a transitory delirious condition, which often readily yields to a purgative and a narcotic. Nevertheless, as Sir George Savage has pointed out, the patient may, during this condition, commit infanticide, and yet remember nothing about it.

Puerperal insanity may be maniacal, melancholic, or demented in form, and each of these is usually acute in nature. If the insanity come on within a week or a fortnight of delivery, the maniacal form is the commonest. Sleeplessness and refusal of food are early symptoms; the actions are often erotic and the talk lewd, filthy, and

blasphemous. The restlessness is extreme. The head aches, the tongue is white, the bowels are loaded, and the pulse much accelerated. Albumin may appear in the urine. The patient generally takes a dislike to her husband and child. She may be suicidal or homicidal.

When the insanity develops a month or more after delivery it is usually of the melancholic form. Here, again, sleep is lacking and food is refused. Suicidal tendencies are very likely to be present, and hallucinations of smell are common. Abhorrence of husband and child is generally a marked symptom.

In all cases of puerperal insanity the milk and lochia may remain normal, but it is more usual for a suppression of one or both to take place, and sometimes the lochia are offensive. Unless a typhoid condition set in, the prognosis is in the majority of cases favourable. They nearly all get well, only, perhaps, to have another attack after a subsequent confinement. Improvement is often ushered in by a return of the milk and lochia, if these have been in abeyance. If death take place it is mostly in cases of the maniacal form, from exhaustion. Sometimes the bodily condition improves while the mental deteriorates, and the patient, though getting fat, remains weak-minded.

A not uncommon cause, both of the insanity of pregnancy and of puerperal insanity, is the shame and remorse caused by an illegitimate pregnancy.

Treatment may be carried out at home if the patient's pecuniary circumstances admit of two nurses and of almost constant watchfulness on the part of the medical man; but if these be impossible, or if the patient be violently homicidal towards her husband or baby, or acutely suicidal, or require forcible feeding, she had better be removed to an asylum. The main indications are to build

up the physical strength, to obtain sleep, to insure quietude, and to protect the patient against her own insane impulses. The infant, if living, should be separated from the mother. The patient's diet should be generous, with abundance of beef-tea, milk, eggs, and perhaps a few ounces of port wine daily. Narcotics are not successful in these cases. If one must occasionally be used, opium is the least harmful, but sleep is best obtained by warm baths and a dose of alcohol at night. It is important to keep the bowels free, and the condition of the vagina should not be forgotten, a boric acid douche once or twice a day being a wise precaution.

The Insanity of Lactation

This may set in at any time after three months from delivery, and is characterized by exhaustion. Many cases attributed to lactation are really puerperal in nature, and it is often impossible to distinguish where the puerperal factor as a cause ends and lactation begins. The patient is pale and anæmic, sleepless and depressed. She may have hallucinations of smell, sight, and hearing. These cases generally get well. The treatment is on the same lines as that of the severer kindred insanities, with the addition of iron and cod-liver oil. When improvement has set in sea air is beneficial.

Since writing the above, I have seen a case which illustrates rather well the insanity of pregnancy and puerperal insanity.

G. E. O., thirty-five, married, was until recently a maid-servant. She became pregnant by the milkman, and suffered so much mental distress when she discovered her condition that he, a young man eleven years her junior, married her in the fourth month of her pregnancy. Two months after marriage she became acutely de-

mented; did not know where she was; neglected her home; cut her stockings into pieces, and was dirty in her habits. During her confinement her mind cleared up, but within a week she was bad again, dazed and demented; would put her clothes on in the wrong order, with the chemise outside; could not remember anything; was again dirty in habits; took no notice of her baby, and had not the sense to suckle it. When I saw her she was much in this condition. No family history could be obtained, but there was an account of her having been subject to some attacks resembling *petit mal*, which would lead to a suspicion of a neurotic history. She was placed under certificate, but died a fortnight afterwards of exhaustion.

2. Epileptic Insanity

Insane epileptics are the most dangerous of all lunatics. Epilepsy may be a cause of insanity; it may arise as an intercurrent symptom during insanity, or may be due to chronic brain disease, such as syphilitic or senile changes, or to injuries. The fits may range in severity from slight *petit mal* to severe seizures, and may occur singly or in large numbers.

In discussing the mental phenomena of epileptic insanity, it will be convenient to consider, firstly, the condition in the intervals between the attacks, and, secondly, that existing at the time of the attacks.

Condition between the Attacks.—In some patients the mental symptoms are so slight that the patient, though weak-minded, can hardly be called insane, although he is, perhaps, peevish and irritable, and has some lack of self-control. Others may be slightly demented, while others, again, are irritable and dangerous if interfered with. When actual insanity exists in the

intervals, the form may be mania, melancholia, dementia, or (rarely) paranoia. There are often hallucinations of hearing and delusions of persecution. Suicidal impulse is not uncommon. Many epileptics are confirmed masturbators, and some acquire bestial and unnatural tendencies, but many of these persons are specious and hypocritical in manner. Exalted religious fervour is a marked symptom in many insane epileptics, but is often combined with extreme irritability and spitefulness, so that commotions are common in asylums through some harmless dement accidentally running against an epileptic engaged in his private devotions, when the latter will often furiously assault him, using at the same time most awful language. The tendency of all kinds of epileptic insanity is towards increasing weak-mindedness and dementia.

Condition at the Time of the Attacks.—This is usually of a maniacal type, though melancholia is not unknown. The excitement may precede a fit; it may take the place of a fit, when it is termed by some 'masked epilepsy,' and by French observers *épilepsie larvée;* or may succeed a fit or fits. The latter is the commonest, and here the excitement is of the kind spoken of as epileptic furor. Only those who have witnessed it can conceive the change which converts the usually mild and docile person into a brutal, bloodthirsty savage. The duration of this period of excitement depends more on the number of fits the patient has had than on their severity. A fortunate circumstance is that the epileptic seizures do not, as a rule, occur without some warnings, easily read by the trained attendant, who is familiar with each individual patient's ways. A certain querulousness commonly manifests itself beforehand, and the usually orderly and fairly contented patient will continually

pester doctors and attendants as to when he is likely to get his discharge.

In epileptic mania a point of great forensic importance may arise as to the patient's responsibility for his actions. It is an undoubted fact that persons while in the condition of epileptic excitement may perform complicated acts requiring some amount of system, and yet remember nothing whatever about them when the normal condition is returned to. Murder has been committed under such circumstances, and the murderer has been at some pains to conceal his crime, yet his mind on his return to consciousness is a blank as to what has occurred during the epileptic state. Some authorities have gone so far as to say that no epileptic should be considered responsible for his actions. There is no doubt that a great many of these unhappy persons have been punished for crimes committed while they were labouring under epileptic excitement, and were irresponsible persons, and that a history of epileptic fits should be a strong point in any criminal's favour.

There is little difficulty in diagnosing epilepsy if the patient be seen while in a fit: the premonitory cry, the pallor, the dilated pupils and strong convulsions, cannot be mistaken for any other complaint, and are familiar to all of us; but in the intervals between the fits the diagnosis of epileptic insanity is not always easy. The fawning, cringing manner, changing on small provocation at a moment's notice to violent pugnacity, is characteristic, as also is the fondness for religious observances, with an utter lack of any idea of living up to them. When there is already no doubt as to the insanity, such signs as scars on the head and face from falling about, or a scarred tongue from bites, may point to the epileptic nature of the mental disease.

In most insane epileptics there is also a peculiar ex-

pression which is difficult to describe, but is nevertheless unmistakable when once recognised. It consists partly in a strained and intense expression of the eyes.

The prognosis in epileptic insanity is bad—indeed, almost hopeless. In a few instances the fits become rarer as time wears on, but only for the case to end in chronic dementia. The tendency is always towards dementia, and the rapidity or otherwise of its onset depends more on the frequency than on the strength of the fits. *Petit mal* seems as injurious in its effects on the brain as is *grand mal*.

A common termination of epileptic insanity is by the patient having a rapid succession of fits and developing what is known as the status epilepticus. The temperature rises, the skin is covered with a clammy sweat, the face becomes cyanotic, the breathing stertorous, and fatal coma sets in.

Epileptic lunatics are too dangerous to be treated at home. If a case come under notice in practice, the bromides in full doses, with perhaps some chloral, are likely to be useful until arrangements can be made for the patient's removal. A great point in treatment is to reduce the quantity of nitrogenous food to the lowest limit consonant with proper nutrition. Stimulants are contra-indicated, for epileptics are prone to acute excitement and even to homicidal impulses after extremely small doses of alcohol. Some years ago, when the London County Council took over the Middlesex County Asylums, they discontinued the small quantity of beer which had been hitherto allowed to each patient and substituted skimmed milk. After a short interval of discontent, the increased tranquillity in the epileptic wards was most noticeable.

Before leaving the subject of epileptic insanity, I wish

to refer to a form of masked epilepsy which some authorities have denied, though I feel well assured of its existence. It generally takes the place of fits. The patient shows no excitement, but will perform automatic acts and have no memory of them afterwards. The condition is somewhat akin to somnambulism. I believe that some cases of so-called kleptomania are due to this condition.

Some years ago I was asked to see a young German lady, a governess, who was under remand for having pilfered several articles of small value, such as Christmas-cards, sweets, and trumpery calendars, from one of the large stores. She was in no need of money, being in receipt of a generous salary from her employers, by whom she was much esteemed. When apprehended she looked surprised, said 'I quite forgot myself,' and offered to pay the value of the goods. No family history was available, but her child-pupils had noticed more than once that she would become suddenly pale and seem to lose herself, but would recover in a few moments. Her facial expression strongly suggested epilepsy to me, and I thought the attacks the children had noticed might have been *petit mal*. I advised the medical gentleman under whose care she was to keep a keen look-out for epileptic symptoms. Before her second appearance at the police-court she had had three undoubted attacks of *grand mal*, in which she bit her tongue and was strongly convulsed. The aggravated seizures were doubtless due to the mental tension under which she laboured. When she was brought up again, the magistrate, after hearing the defending counsel, declined to listen to the medical evidence, and expressed his intention of sending the case for trial; but the prosecuting counsel, after a conversation with the two medical witnesses, was so convinced of the

truth of our contention that he generously withdrew from the prosecution, whereupon the magistrate discharged the accused on condition that she was sent back to her friends in Germany. I never heard any more of the case.

3. Syphilitic Insanity

Syphilis, both hereditary and acquired, has already been spoken of as in all probability the bed-rock cause of general paralysis (*q.v.*).

It does not follow that because syphilis and insanity coexist there is necessarily any pathological connection between them. The patient may already have been insane when he contracted syphilis. I have seen several such cases. Instances also occur in which the patient develops insanity while his secondary symptoms are in full swing. Here there is very often an insane family history; the patient has become depressed and hypochondriacal on the subject of his complaint, and develops melancholia. The cause here is purely a moral one—a form of syphiliphobia. For my own part I was sceptical as to the power of the syphilitic poison in the early stages to cause insanity until I met with the case I now give a short account of.

A gentleman, aged forty-eight, consulted me on June 30, 1901. He had a typical primary sore on the glans penis, which he had paid no attention to, and when I saw him secondary symptoms had already manifested themselves. I prescribed a course of grey powder for him, but he did not keep the appointment he had made, and I heard no more of him until October 30, 1901, when I was asked to go and see him at his house in the country. He then had symptoms of commencing meningitis—intense headache, photophobia, and vomiting, with a temperature of

102° F. He acknowledged that he had only pursued my treatment for a fortnight, when, as his symptoms had all disappeared, he concluded, contrary to my cautions, that he must be well. Mercury by mouth was recommenced, but without good effect, the symptoms of meningitis becoming more marked, and on November 9 he was delirious, had several convulsions, and there was double optic neuritis. Mercurial inunction was now tried, and by the middle of January, 1902, his more urgent symptoms had subsided, but he was dull, forgetful, and incoherent, and occasionally dirty in his habits. Here I lost sight of the case, but heard long afterwards that in June, 1902, he became noisy and maniacal, and was removed to a private asylum, where he died in July, 1902. No post-mortem was held. This was a case either of syphilitic meningitis or of gummatous tumour, causing grave cerebral symptoms within five months and death within fourteen months of the primary infection, and I looked upon it as a rare one. Since, however, I attended this case, Sir William Gowers has seen hemiplegia three months after primary infection.

Most commonly true syphilitic insanity shows itself in the late stages of the disease, perhaps many years after infection, and is due to coarse disease of the brain or its membranes, to syphilomatous growths, or to arterial disease with or without hæmorrhages. As might be expected, the symptoms are those of a gradually progressing dementia, generally associated with some form of paralysis. Ptosis and strabismus, rare in other forms of insanity, are common in this. Impaired muscular power and epileptic fits may be present. In syphilitic epilepsy the fits are of a less severe type than in ordinary epilepsy, and the tongue is not so frequently bitten. This epilepsy tends to weak-mindedness rather than to

mania. Where multiple cerebral tumours are present the symptoms may closely resemble those of general paralysis. Accessions of severe nocturnal headache are a valuable diagnostic symptom. The sight and hearing are often impaired.

Treatment is only likely to be of use in slight or comparatively recent cases, and in these the iodides occasionally produce good results. If a history of imperfect early treatment can be obtained, it will be well to give the patient a course of perchloride or of iodide of mercury, if the kidneys be sound. In cases occurring in advanced life, treatment of any kind generally proves useless. Many cases of syphilitic insanity do very well under home care for quite a long time, but sooner or later their removal to an asylum is likely to become necessary. The troublesome case I have just quoted was only placed under asylum control within three weeks of his death.

Syphiliphobia

This is an extremely distressing mental condition, and one not infrequently met with in general practice. It therefore demands some mention here. It may occur, as has been already mentioned, in a person who actually has syphilis, and who becomes so miserable and self-abased over his trouble that he begins to fear he is a centre of contagion to everyone around him, and that perhaps even his touch or his breath is poisonous.

Suicide has been committed under such circumstances. Other sufferers are often innocent, ignorant young fellows, generally of neurotic inheritance, who may once in a way have been led to commit some indiscretion with a woman.

Remorse follows, and then comes dread of venereal

infection, with consequent sleeplessness and hypochondriasis. These patients commonly wander from one doctor to another, and often ultimately become a source of revenue to quacks, who naturally feed the fire of their fears.

Such cases require very careful and sympathetic handling. Any attempt to laugh the victim out of his terrors is bound to be a failure. If his confidence can be gained, it must be gently and patiently explained to him how improbable, or even impossible, it is for him to have acquired the disease which he dreads. Such an explanation may be required again and again at subsequent interviews, and the patient is apt to become a perfect nuisance to his doctor, but it must never be forgotten that his mental sufferings are very real. Medical treatment should be directed towards improving the general health. Cod-liver oil is often useful. The main thing, however, is kindly, patient, and hopeful reasoning. Some of these cases drift into actual insanity.

4. Alcoholic Insanity

In considering this subject it will be best to divide it into:

1. Acute alcoholic delirium, or delirium tremens.
2. Insanity from drink (proper).
3. An incurable condition of chronic mania or dementia, which may be a sequel to repeated attacks of either (1) or (2).

Acute Alcoholic Delirium, or Delirium Tremens, is the form most commonly met with in private practice, and, although some authorities do not include it among the insanities, yet it is most certainly a 'perversion of the ego,' and as such demands notice here. Its first

stage is ushered in by restlessness, sleeplessness, and tremulous irritability, and if these symptoms be not checked the patient passes into the second stage—that of delirium. He talks incessantly, and has disagreeable hallucinations of sight, mostly bearing on small animate objects, such as ants, beetles, rats, spiders, or even babies. Hallucinations of hearing, taste, and common sensation may be present, but are not so usual as those of sight. The patient cannot concentrate his attention. He mistakes the identity of those about him. Very commonly he is to be found trying to pack his portmanteau, under the impression that he is going on a journey, but he never gets much further in his packing. Sometimes he makes attempts to dress himself, with ludicrous results. Thus I found one patient in bed with a tall silk hat on. About the same time I met another attired in a night-shirt, hat, and great-coat, struggling violently with the hall-porter of the London flat in which he resided, and declaring that he must go round at once to the Pier Hotel, being under the impression that he was staying at a popular health resort. Motor restlessness is always extreme, and if the attack be at all acute the delirium is one of apprehension and terror. Convulsions may occur, the appetite is in abeyance, the skin covered with profuse perspiration, the tongue furred. There may be nausea and vomiting. The temperature may be normal, but is more likely somewhat raised. This and the muscular condition are important features as regards prognosis. A sharp rise in temperature may indicate meningitis, and in any case it is of unfavourable import. The disease is one of asthenia, and cardiac weakness and irregularity are common. The patient may die of exhaustion within three or four days. I have seen two cases in which the patients (they were both women) sat

up suddenly in bed while conversing and fell back dead from heart failure.

Ordinary cases of uncomplicated delirium tremens usually get well in a week or a little more. They can be quite successfully treated at home if the patient's means allow of two trained attendants. The poorer class of patient had better be removed to the workhouse infirmary, where the justice has the power of adjourning the case for any period not exceeding fourteen days. If during this period recovery takes place the patient will be discharged without its having been necessary to place him in an asylum.

If delirium tremens be seen in the first stage, an aperient, a few doses of a bromide mixture with a chloral draught at night, will often do all that is required. In the second stage also sleep and free purgation are what one aims at. A dose of calomel followed by a black draught is most useful. A routine treatment of mine is to give, in addition to these, 20 grains of sodium bromide with 5 grains of chloral hydrate every four hours for the first day, with 15 or even 20 grains of chloral at night. Of course, the heart must be carefully watched. If no improvement result, it is best to discontinue the chloral in the mixture on the second day, but the night draught may be safely repeated. If the chloral fails, $\frac{1}{2}$ grain of morphia hypodermically will generally insure good sleep, but, of course, an interval must be allowed between. Rest in bed, with careful nursing and plenty of fluid nourishment, are essentials. Great difference of opinion exists as to whether stimulants should be allowed or not in these cases. My own impression is that when seen in the first stage an attack of true delirium tremens may more likely be warded off by allowing the patient a small quantity of the stimulant he has been used to than by

knocking off his drink altogether. If the second stage have set in, he is better without stimulant. The attack cannot now be cut short, and he will have to go through a week's illness at the least, so the opportunity may be taken of getting rid of the alcohol in his system as far as may be.

True Insanity from Drink, as distinguished from delirium tremens, is a disease of much longer duration and of graver import. Before it declares itself the patient has most likely already begun to show some of the psychical symptoms of chronic alcoholism, such as moral deterioration and diminished will power; he becomes cowardly and untruthful; sometimes there is a tendency to wander about the country in the manner of a tramp. Gradually he becomes dissatisfied and suspicious, and may make false accusations against his wife of unchastity. Now hallucinations and illusions develop, bearing on this subject in all probability, and although the patient may continue at his work, he is dangerous and not to be trusted, and may end by killing his wife, the supposed paramour, or himself. When thoroughly developed this form of insanity may assume a melancholic or a maniacal type, with exalted delusions of wealth and position. There may also be tremors and alterations in speech, but the marked improvement under treatment and suppression of alcohol soon clears up any doubt which might have existed as to general paralysis. Hallucinations of hearing and touch, which are rare in delirium tremens, are common here, as also are delusions about plots and suspicions of poison in food. Asylum treatment is always indicated in these cases. Many of them get perfectly well, but the improvement is not rapid, two years sometimes elapsing before recovery is complete. The attacks may occur

many times over in those who persist in their intemperate habits, causing much misery to the friends, and eventually ending in incurable chronic mania or dementia, as has been already mentioned. Epilepsy, also, is sometimes a concomitant.

The Dementia of Alcoholism demands no especial notice.

Dipsomania, or Periodic Alcoholism

While on the subject of alcoholic insanity, it will be convenient to consider this condition, though there is little in common between them, the mental state here being the cause instead of the effect of alcoholism.

True dipsomania differs from drunkenness in being a periodic seizure, and Dr. James Shaw well describes the difference when he says: 'The dipsomaniac drinks at intervals only when the impulse seizes him, the drunkard at any time, and always when he has the chance.'

Dipsomania is rare before the age of thirty. A neurotic inheritance can nearly always be traced. The attacks are ushered in by depression, headache, restlessness, and sleeplessness. Then comes the irresistible craving, when the sufferer will swallow anything alcoholic to gratify it, if he cannot obtain wine, beer, or spirits. I knew an old country surgeon who used to drink up his tinctures. Dispensers have been known to take tincture of rhubarb, and house-painters to swallow varnish. Methylated spirit, paraffin oil, and turpentine have all been pressed into the service. Each attack may last for days or weeks, and leave great mental depression behind it. The intervals between the attacks are variable in duration, sometimes months, occasionally even years. Overwork or overanxiety will often bring an attack on. Confine-

ment in an inebriates' home is almost the only treatment likely to prove beneficial, but the difficulty consists in obtaining the patient's permission. He will rarely give it unless he have got into trouble with the police and been brought before a magistrate, when he may choose a sojourn in a home in preference to detention in gaol. Dr. J. F. Woods has obtained some good results in dipsomania, in alcoholic insanity, and in ordinary alcoholism by hypnotic suggestion.

If there be strong hereditary tendency in dipsomania, any treatment is almost hopeless.

5. Post-Operative Psychosis

This condition is rather rare, but I have seen some half-dozen cases. The severity or mildness of the operation seems to have little to do with the likelihood of insanity supervening. An insane heredity is usually present. Worry before operation is a very common antecedent of post-operative insanity. The condition mostly comes on in about three to seven days after operation, but in some cases it starts immediately afterwards, and these, I think, are often due rather to the anæsthetic than to the shock of the operation. There is always a confusional condition of mind, with delusions and hallucinations and great excitability and restlessness. Most cases have to be placed under certificate, but some get well in a few days, and these I have always thought to be post-anæsthetic in nature rather than post-operative.

Example.—In October, 1903, I saw, in a workhouse infirmary, C. J., aged twenty-three, married eleven months. No family history obtainable. Ten days previously she had been operated upon in hospital for a uterine fibroid, and had gone on well for a week, when she

became excited and unmanageable. When I saw her she was noisy, violent, restless, and sleepless; said her mother had risen from the dead and was lying beside her in bed. She heard imaginary voices and also bells ringing. She said she could see people jumping through the windows of the ward. She mistook the identity of those around her. She was placed under certificate.

6. The Insanity of Adolescence

Under this title I propose to deal with a group of mental conditions, closely allied to and often overlapping one another, which have been written of under various names, such as hebephrenia, catatonia, pubescent insanity, adolescent dementia, dementia præcox.

The period of adolescence is usually considered as extending from the fifteenth to the twenty-fifth year.

The age of puberty brings with it dangers to both sexes. At that period both mental and physical faculties are undergoing a great change and strain. The brain is developing, and study makes considerable demands upon it. Bodily growth is going on, and the sexual instincts are developing and revealing glimpses of a new world to the adolescent. Under such circumstances it is quite conceivable that the mental balance can be easily upset, especially where hereditary neurosis exists.

True adolescent insanity occurs almost solely in those hereditarily predisposed to insanity. It is occasionally ushered in by maniacal excitement, but almost equally often the patient is depressed and too self-conscious, the latter condition often amounting to disagreeable self-conceit, when he assumes an impudent demeanour and imagines slights to his dignity, very likely relapsing into tears directly afterwards; indeed, laughing or crying

with inadequate cause are common symptoms, and he may be at one time depressed and at another boisterously optimistic. He may also be hyper-religious and falsely accuse himself of crimes. Although melancholic and maniacal symptoms may alternate, the tendency of the disease is in most cases towards a steadily increasing dementia. Headache and constipation are usual, and sleep is disturbed. Oral sepsis is common, owing to the tongue being very little used. Masturbation is a common complication. Occasionally these patients are suicidal, and in rare instances homicidal. As dementia advances, destructive tendencies show themselves, but actual violence becomes more rare. Many varieties of adolescent insanity have been described, ranging between slight imbecility on the one hand and a distinctly criminal type on the other; but in most of them the dementia slowly increases, and slovenly and even dirty habits are present. A variety worthy of note is the dementia præcox catatonica, where cataleptic rigidity of certain sets of muscles is a marked symptom.

This form of insanity is more than twice as common in males as in females. In addition to the predisposing causes already spoken of, exciting ones are overstudy, too rapid growth, and general ill-health. Severe influenza has been thought to be a cause. Masturbation may be a cause as well as a symptom.

These patients should never be allowed to be at large, in spite of the grief caused to the parents by the removal of their child. Unfortunately, the prognosis is usually, as already said, a gloomy one, and treatment is of little avail. Kraepelin has found hereditary taint in 70 per cent. of his cases. He says that 10 per cent. become cured, but that 60 or 70 per cent. become severely demented. Symptoms must be dealt with as they arise.

Moral control may effect some improvement. It is possible that an attack might be avoided by great care in the early teens on the part of the child's guardians in providing plenty of outdoor physical exercise, in the avoidance of overstudy and mental strain, and the prevention of bad habits by well-timed and kindly caution. It behoves the family physician to be keenly on the alert to note any slight change from the normal in the psychical condition of adolescents of either sex. Irreparable mischief may be prevented if the symptoms be taken in time. Should there be any suspicious symptoms in an adolescent member of a family with insane history it would be wise to obtain the immediate advice of a physician having special experience in that class of cases.

Adolescent insanity, or dementia præcox, should not be confounded with a neurasthenic and hypochondriacal condition sometimes occurring in youths, generally of neurotic history and addicted to masturbation, and often aggravated by the perusal of quack literature bearing on that habit. This malady is, as a rule, only temporary, and if dependent upon masturbation, disappears soon after the habit is relinquished. Good influences, a healthy outdoor life, and avoidance of bad habits and pernicious literature are the best curative agents.

C. F. A. came under my observation in 1894, when he was eighteen years of age. There was a double heredity of insanity. He had been spoilt by his mother, and allowed to stay away from school whenever he liked, but when he did go was said to learn fairly well. At the age of sixteen he altered in manner, took still less interest in his school-work, became conceited, and wandered about abstractedly. He was placed in a home, and seemed to improve somewhat under discipline. When I saw him he had relapsed, was sulky and suspicious, had

a great idea of his own talents, thought that he was intended by nature for a statesman, and constantly wrote long and incoherent letters to the members of the Cabinet. He was known to practise self-abuse. On one occasion he disappeared from home for thirty-six hours, and when found wandering by his friends made a desperate attack upon them in endeavouring to escape. He was removed to an asylum, where he gradually became more demented and a shameless masturbator. When last I heard of him he had become the subject of chronic and hopeless dementia.

7. The Insanity of Rheumatism and Gout

The connection of the uric acid diathesis with insanity is of clinical importance, and demands some notice here. Some authors lay great stress upon it, while others practically ignore it. In my opinion, a proper recognition of the relationship will often aid materially in treatment.

The forms of insanity most likely to be found associated with rheumatism are mania, melancholia, and acute dementia or stuporous insanity, and an important fact to be remembered is that chorea frequently accompanies these. Several cases are on record in which an attack of acute rheumatism has been followed by insanity and chorea. In rheumatic insanity the mental condition may ameliorate on an accession of the rheumatism, or the converse may happen.

Gouty insanity is usually maniacal in form. The attacks may alternate with those of the arthritis, and cases have been known where an attack of acute insanity in a gouty person has undergone quite sudden improvement on the supervention of a typical attack of gout. A

form of dementia sometimes develops in the declining years of a person who has been subject to gout all his life, but whose gout has disappeared about the age of fifty or sixty. Here the prognosis is bad, but in most other forms of insanity connected with the uric acid diathesis much benefit may be hoped for from treatment with the salicylates and colchicum.

8. Plumbic Insanity, or Saturnine Encephalopathy

Chronic lead-poisoning is occasionally a cause of insanity. Acute mania of a somewhat fleeting character is the commonest form observed, usually preceded by insomnia and headache, and accompanied by hallucinations of sight. General paralysis has occasionally been diagnosed during lead-poisoning, though examples are rare. In these cases syphilis must always have been the predisposing, and plumbism merely the exciting cause. A kind of spurious general paralysis, however, is not uncommon, in which the patient may have exalted notions, restlessness, tremors, and other typical symptoms, all of which clear up completely under treatment. This condition may follow closely upon the acutely maniacal form. Epilepsy also may be a result of lead-poisoning. In all the above cases the blue line on the gums will greatly assist in the diagnosis, and in some few the typical symptom of paralysis of the extensor muscles of the forearm may be present. Optic neuritis also is commonly to be found.

It is well to bear in mind that every case of lead-poisoning must be reported to the Chief Inspector of Factories, Home Office, London, S.W. No special form is required, and the fee paid is the usual one of half-a-crown.

The treatment is that followed in general lead-poisoning.

The three foregoing varieties — namely, rheumatic, gouty, and plumbic insanity—seem especially fitted for the therapeutic methods of treatment by hot air and by the high-frequency electrical current.

9. Climacteric Insanity

This occurs in women about or shortly after the menopause, the immediate cause doubtless being the change in the system caused by the cessation of the menstrual function. Worry and anxiety are also causes, and secret drinking a fertile one, drink often being resorted to with a view of relieving the depression, debility, and discomfort attending a prolonged 'change of life.' Hereditary predisposition to insanity can commonly be traced. Melancholia is the commonest form of climacteric insanity, and the delusions are of a distressing character. The patient thinks she has ruined herself and her relations by a misspent life; she is plunged in despair and religious despondency, and is almost sure to be suicidal. Mania may alternate with this melancholic state, or a form of dementia may set in quite early in the course of the disease, a premonitory symptom of this being loss of memory. Where ovarian complications exist hallucinations of smell are especially common.

The prognosis is generally favourable if the case be promptly dealt with, say within two or three weeks of its onset. The more time that is lost in beginning treatment, the more remote do the chances of recovery become, but even in the most hopeful cases improvement is generally slow. If recovery take place, it will probably be permanent. If secret drinking be a factor in the case, any chance of recovery is almost precluded.

As regards treatment, immediate removal to an asylum is the patient's one chance. If complete recovery do not take place, she often gets well enough, after a longer or shorter period to return to her home and friends, and spend the rest of her life among them. Some cases, however, go from bad to worse; they develop abusive excitement, are noisy and dangerous, and use filthy and obscene language. Sooner or later these cases end in fatuous dementia.

While speaking of climacteric insanity, it is worth while noting that recoveries from long-standing insanities of other kinds have sometimes taken place at or about the change of life, the reason probably being the alteration from active sexual life, with its turmoils, physical and mental, to a quieter and more placid existence.

A climacteric insanity occurring in men between the ages of fifty and sixty has been described by some authors, the causes being given as heredity and the weakness of impending old age. Some cases are said to have recovered.

10. Circular Insanity or Psychorhythm

This form of insanity is characterized by alternating attacks of mania and melancholia, between which there may or may not be an interval of normal mental health. It is a rather rare condition and is more frequent in females. It is commonest between puberty and the age of thirty, but may appear later in life, though seldom after fifty. There is generally heredity of insanity, epilepsy, alcohol, chorea, or hysteria. It often commences with spells of excitement and depression, which alternate and gradually increase in severity. As a rule the maniacal attack is the less severe of the two, and the melancholic

one is often the first to attract observation. It is a simple depression without delusions, but often of a stuporous character: sleep is broken, there may be refusal of food, and the patient may neglect the calls of nature. In the maniacal attack the insanity seems to be of the moral type, and artfulness and mischief are its predominating characteristics. The stages may occur in any order, but the commonest sequence is melancholia, mania, lucid interval. The change between melancholia and mania may be sudden and take place during the night. The length of the phases varies much. It may be only a few days or as much as a year. The lucid interval may be absent altogether, and if present is usually of short duration; it is more likely to occur in the course of long attacks, and occasionally to be so long itself as to lead to the supposition that the patient is cured; and these are the cases of circular insanity most likely to be met with in private practice, the patient having been discharged by the asylum authorities under this impression. Complete cures are exceedingly rare, the tendency of the disease being towards dementia. It is likely to be mistaken for acute mania or for melancholia if the cyclic changes are not waited for. Home treatment is quite out of the question.

11. Masturbatic Insanity

Masturbation may either cause insanity or may be a symptom of insanity—two very different conditions. It occurs in both sexes, but is probably much commoner in the male.

Where masturbation causes insanity, I believe it to be always associated with heredity as a predisposing cause. It is, unfortunately, too true that many a schoolboy learns the habit from his fellows, but the healthy-minded boy

with no neurotic inheritance puts it behind him when he realizes its disgusting nature, or at any rate later, when other attractions claim his attention. The neurotic, however, handicapped from birth with weak inhibitory power, is prone to become a slave to the vice.

Masturbation is most generally commenced about the age of fourteen, but sexual precocity is common in those with neurotic inheritance, and cases are on record where it has been practised as early as the age of five.

The symptoms of insanity from masturbation are an exalted idea of self-importance and 'bumptious' conceit, though in some patients shyness is a marked characteristic. Delusions about secret enemies and calumnies are common. There may be religious depression with delusions of having committed the unpardonable sin.

The patient hears whisperings and smells offensive gases. Sometimes there is religious exaltation, with various corresponding delusions, the patient thinking he is some holy person. The pupils are commonly dilated, the heart's action weak, the extremities cold. Pallor of the face is nearly always present, and I myself attach great importance to this symptom.

The prognosis in these cases is always gloomy. The tendency is towards dementia; indeed, it is often impossible to differentiate between masturbatic insanity and the condition described as dementia præcox. Many devices, such as blistering the prepuce, have been resorted to with a view to preventing the bad habit, but it is always returned to at the earliest possible opportunity.

Where masturbation sets in as a symptom during the progress of ordinary insanity, it adds greatly to the gravity of the outlook. It is commonest as a complication in puerperal insanity, in acute mania, and in the earliest stage of general paralysis.

12. Influenzal Insanity

Insanity may occur either during or after an attack of influenza. Should it develop during the febrile stage it is usually of the maniacal type, but this psychosis is rarer than the melancholic type which is likely to be a sequel to influenza, showing itself perhaps a few days, or perhaps many weeks, or even months, after the febrile condition has passed away. In the maniacal form the mania is generally acute, and may necessitate treatment in an asylum. Hallucinations are common, and food may be refused. The melancholic variety will most likely commence with sleeplessness, dreary depression and hopelessness, with inability to concentrate the attention and an acute consciousness of mental disability. This condition will likely drift into acute melancholia with suicidal impulses. In this form, as in the maniacal one, asylum treatment often becomes necessary. In both forms there is almost always an insane heredity, and both tend towards recovery sooner or later, though each may possibly terminate in chronic mania or dementia. Treatment must be based upon the lines laid down in the sections on Acute Mania and on Simple Melancholia. A useful drug in the treatment of all influenzal insanities is the quinine salicylate.

General paralysis may develop during or after influenza, but in such cases, the latter is now looked upon as the exciting cause merely in an already syphilized person.

Patients who have previously had an attack of any kind of insanity are prone to break down again mentally if they contract influenza.

Sir George Savage has pointed out that puerperal cases complicated by influenza are apt to assume a delirious and dangerous type.

13. Moral Insanity

Moral insanity is one of the most complicated conditions in the whole domain of psychology, raising as it does the vexed question as to the legal responsibility of the insane. Dr. Prichard was the first to write on this subject, when, in 1835, he insisted on the fact that 'insanity exists sometimes with an apparently unimpaired state of the intellectual faculties,' and gave a definition which, put briefly, runs 'That moral insanity is madness consisting in a morbid perversion of the natural feelings . . . without any remarkable disorder or defect of the intellect or the reasoning faculties, and without any insane hallucination.' The late Dr. Blandford, in his lectures, challenged this theorem, and denied that absence of the moral sense proves or constitutes insanity, any more than its presence proves sanity, and said that madness, if it exist, must be demonstrated by other mental symptoms and not by acts of wickedness alone. He was of opinion that the authors who have most strongly upheld the doctrine of a moral insanity and morbid perversions of the moral sentiments have often underrated or neglected the intellectual defect or alteration observable in the patient, and because no delusions have been found it has been assumed that the intellect is not impaired. He also pointed out that many people of altered intelligence have not as yet reached the stage of delusion, and many recover from the latter or from the stage at which delusions are present, yet do not recover their full intellectual powers, but remain semi-cured and semi-insane. He said it is quite true that the moral sense is absent in many lunatics, all notions of duty and decency being destroyed in the general overthrow of the mind, but it is also true that there are perfectly sane people who,

from the habit of continual vice, are devoid of moral sense to a greater or less degree.

I have mentioned in a former chapter that moral insanity is closely akin to imbecility. Heredity is nearly always present as a predisposing cause. Moral insanity may be found at any age, even in early childhood, and examples sometimes appear in the daily papers of small children drowning, or perhaps burying alive, an infant brother or sister. It may follow a blow on the head or epilepsy, and in these cases the prognosis is extremely bad. Among the mental symptoms are abnormal depression or hilarity. There may be a tendency to suspicion, especially of marital fidelity, and a proneness to attribute false motives; impulse to do violence to self or others is common, and suicide or homicide may be the result. Sleep is disturbed, there is headache of a dull character, disordered digestion, and perhaps palpitation of the heart. Many sufferers from moral insanity become kleptomaniacs, and will take most artful precautions to conceal their criminal acts. Many are liars and boasters. It is often said of these patients by the asylum nursing staff that they are more bad than mad. Periodical dipsomania may be a symptom, as may also be an inability to control the animal instincts. Litigious insanity is a form of moral insanity; so also may be the tendency to write obscene and libellous anonymous letters. This is common among women; but I have seen two cases in which a man was the delinquent, and in each of these there was a bad family history of insanity. A usual trick of this kind of anonymous letter-writer is to occasionally send one to himself, so as to avoid suspicion fixing itself upon him. The general mental capacity and the memory may be excellent throughout. When moral insanity occurs in old age the patient may

take to gambling and horse-racing and frequent the company of low prostitutes. An example in English history occurs to one in the case of that great King, Edward III., who in his sixty-fourth year became madly and disgracefully infatuated with Alice Perrers.

The prognosis is, as a rule, bad; but some cases have been known to recover, and some of these recoveries have taken place under private care. The responsibility of such a case is, however, very great. In the congenital variety careful watchfulness during childhood and youth may ward off the graver symptoms.

The question of the legal responsibility of the insane has always been a vexed one between lawyers and doctors. The so-called legal test is whether a criminal knows right from wrong. The alienist physician maintains that certain persons labouring under moral insanity may perfectly well distinguish right from wrong, and yet have irresistible promptings to do that which is wrong. The task of the medical witness for the defence in such a case is always a difficult and generally a far from enviable one. Here, again, I think I cannot do better than quote from the valuable suggestions of that eminent authority, Dr. Blandford. He says:

'If you are asked if you think he knew right from wrong you may answer: (1) That it is not possible so to enter into and examine the internal consciousness of an insane man at the moment of the commission of a crime, even if we are present, as to be able to argue as to his knowledge of the wrong he is doing. (2) That the defect of mind presumed to be present, whether insanity or imbecility, implies an absence of that perfect working of the intellect and feelings on which knowledge necessarily depends. (3) If we are told that many of the insane do know right from wrong, and that they are kept

in order in asylums by this knowledge, by fear of punishment and hope of reward, we answer that their knowledge of right and wrong is child-like and imperfect, that the system of rewards and punishments is one adapted to the insane as is that which we apply to children, and that for violence and grave offences committed in an asylum no one thinks of holding the patients responsible, or of handing them over to the law.'

The presence of the stigmata of degeneration would be a valuable point in the defence of a person afflicted with moral insanity and charged with a crime (see p. 53).

14. Borderland States

These are cases of nervous weakness which do not quite fit in with any of the recognised forms of insanity. The symptoms range from extremely trivial ones to considerable alterations in the mental condition. The intelligence generally remains unimpaired, but there is weakness of will. They are far from uncommon in the experience of the general practitioner, but rarely do they find their way into asylums. Though these persons may never come to be looked upon as actually insane, their family history is usually a neurotic one; they are of a degenerative type, and they may beget lunatics. They are not, as a rule, dangerous. They are in fact eccentrics. A good many are quite brilliant in some directions, though generally showing a lack of mental balance. Friends with a bias of partiality are prone to speak of them as possessing the artistic temperament, while others, less charitably disposed, will dub them cranks. Their genius if present is erratic, and there is a lack of perseverance and determination in all their work if ever they do any work at all. They commonly have vague and care-

less ideas as to their pecuniary obligations. Some of these cases are so nearly allied to mild imbecility that it is impossible to draw the line between the two conditions. The term obsession is used to indicate defects of the will in these cases, and Regis has divided these obsessions into (1) The obsessions of indecision; (2) the 'phobias,' or obsessions of fear; (3) irresistible propensities or morbid impulses.

(1) **Obsessions of Indecision.**—In these the patient is continually in doubt as to whether he has done properly or otherwise in any action he has undertaken; he constantly questions his own acts, wondering whether he has made a *faux pas* in his manners or has unwittingly wounded someone's feelings; or, if he be religiously inclined, whether he has committed some trifling sin. These doubts range from the most ordinary occurrences of every-day life, such as whether or no he has locked a door, or the number of shops he has passed in a certain street, to matters quite closely connected with his business affairs. Many of us have felt these obsessions of indecision in their mild forms.

(2) **The Phobias, or Obsessions of Fear,** are less common but more distressing to the patient than the above. One of the commonest is agarophobia, or fear of open spaces, and another is claustrophobia, where the sufferer cannot bear to be in a confined space, as a room or a railway carriage. Hæmatophobia, or fear of blood, is also a rather well-known condition, and often runs in families. Cremnophobia, or fear of precipices, has been described; but all cases of this can scarcely be fairly included among symptoms of the borderland state, for many persons of perfectly sound mind have an aversion to looking down from a great height.

(3) **Irresistible Propensities or Morbid Impulses**

vary in strength from the veriest suggestions of silly acts to serious impulses to crime. They are often suggested by association, and hence we are indebted for occasional epidemics of suicide or of murderous outrages by revolver or knife on girls by young hobbledehoys through jealousy. A good example of suicide through association of place is the following:

In the year 1856, John Sadleir, M.P., a forger and fraudulent bank director, said to have been the original of Mr. Merdle in Dickens' 'Little Dorrit,' committed suicide on Hampstead Heath by swallowing prussic acid. The medical man called to see the body became afterwards a hospital surgeon and a well-known London consultant. More than forty years after Sadleir's death this gentleman committed suicide on the same spot and by the same means as Sadleir.

Dipsomania has been classed by some authors among these irresistible propensities, though others include it under the head of moral insanity. According to Krafft-Ebing, many cases of sexual perversion also come under the same category, but in diagnosing these it must be difficult to exclude ordinary criminality.

A good many of the obsessions of indecision improve as years go on and the will and the power of determination become stronger, but in all borderland cases where the hereditary taint is great there is always the fear of their passing into some form of true insanity—most likely paranoia or melancholia. In treatment, rest and change of scene have been recommended, as have also been iron tonics, electricity, both faradic and static, and more especially the current of high frequency.

Dr. Walsh has told me of a borderland case under his care which benefited greatly under this treatment—at any rate, for a time. He was a bank clerk, aged thirty-

four, with no family history of neurosis; had lived a healthy life, but for two years had had symptoms of claustrophobia; could not ride in a tram, disliked cabs and railway-carriages, and was 'nearly dead' after a railway journey to Felixstowe—'thought too many people might get into the carriage.' He had occasional attacks of left hemicrania lasting a day or two. His sight had failed of late. Under a course of high frequency (fifteen treatments) the patient greatly improved generally, and lost his phobias. He was going on the Continent to a spa, and appeared to develop his old dread a few days before leaving, but eventually went away in company with a friend.

15. Feigned Insanity

This is more frequent than might be supposed, and is commonest among those of criminal type. Most of the cases come under the notice of the medical officers of our prisons, the object, of course, being to get to an asylum, and thus avoid hard work, besides insuring a comparatively generous diet. Soldiers will feign insanity to avoid military service. Occasionally this form of malingering is seen in workhouses and in general practice, the aim often being to lie low in the haven of a lunatic asylum under a false name in order to avoid the pressing attentions of the police. The usual fault of all these pretenders is that they overact their part; the absolute absurdity and inconsistency of their antics is more than appears in any genuine form of insanity, even acute mania. Moreover, if watched for a few hours, it will be found that the condition is not kept up. Sooner or later tired nature gives in, and the pseudo-maniac falls into the calm sleep of exhaustion, perhaps to recommence his unruly behaviour after a good night's rest. Where

chronic mania is simulated the malingerer generally makes the mistake of answering every question of whatever kind incorrectly, a condition which never occurs in real insanity. The most puzzling cases to diagnose are those where auditory hallucinations are counterfeited. Most of these persons have had some small experience of the insane, and it is as easy for one of them to say that he is constantly annoyed by voices in his ears as it is difficult for the medical man to decide that such is not the case. Close watch must be kept on the patient, especially when he thinks he is unobserved. His actions are soon found to be inconsistent with those of one suffering from hallucinations of hearing. There is absence of the sudden turning of the head and attitude of listening, and though the person may simulate an expression of suspicion, this usually changes to a comfortable, contented look when he thinks he is unobserved. Such cases occasionally pretend to think that poison is mixed with their food, but they never refuse it for long together.

16. 'Police-Court' Insanity

The majority of the lunatics, wandering or otherwise, who fall into the hands of the police do not get as far as the police court, although they may very likely have shown some violence of demeanour. When arrested they are taken before the inspector at the station, and thence to the workhouse infirmary, where they are dealt with by the judicial authority as already described. The mentally afflicted persons most likely to make an appearance before a stipendiary are early general paralytics, early paranoiacs, early melancholiacs, epileptics, imbeciles, cases of moral insanity, and puerperal cases, and the offences with which they are charged will

probably be either violent homicidal assaults, indecent exposure, incendiarism, infanticide, attempted suicide, and occasionally drunkenness. In all these cases the evidence of the family physician, who is intimately acquainted with the patient, his hereditary history, and any physical or mental alterations which have lately taken place in his condition, will be most valuable, generally carrying more weight than that of the most skilful expert, and often saving the delinquent from suffering for an action committed while in a state of irresponsibility.

Homicidal Assaults.—Many of these are committed by epileptics while in a state of fury, and it is important to remember that these persons may be in a state of epileptic excitement without having recently had any fits at all, the excitement taking the place of the fits, and that while in this condition they may, as already mentioned, commit crimes of violence and have no recollection afterwards of what they have done. Some epileptics may go for years without fits, earning their living all the time and bearing the reputation of sober, law-abiding citizens, and then suddenly develop one of these attacks and commit murder.

Violent assaults may be committed by paranoiacs in the earlier stage. The patient is tormented by delusions of persecution, and thinks he is watched, followed, and mocked at by gangs of conspirators. He bears his imaginary trials for a longer or shorter time, according to his temperament—whether patient or irascible—but at last he retaliates, and one day turns on an inoffensive passer-by and knocks him about as being the cause of his troubles.

Theft—Kleptomania.—The term 'kleptomania' has earned an evil repute through being so commonly made

the line of defence in cases of ordinary vulgar shop-lifting, but there is no doubt that such a mental disease does exist, and is a form or an accompaniment of moral insanity. The ability to prove strong neurotic heredity in these cases is likely to be of the greatest service later at the sessions; for if kleptomania be pleaded as a defence, the magistrate will send the case for trial. I have already expressed the opinion that many acts similar to kleptomania, of theft of useless and valueless articles, are performed during the state known as masked epilepsy. The possibility of an epileptic cause of this kind should never be forgotten.

General paralytics in the early stage are prone to commit theft under the impression that the article belongs to them. Their pilferings are always perpetrated in a clumsy, blundering manner, without any attempt at concealment, and, if the larceny be successful, the article is likely to be lost or given away the next moment.

Many semi-imbeciles are quite unable to withstand the impulse to steal, especially when they are of the type tending towards moral insanity.

Indecent Exposure should at once suggest to the physician the probability of commencing general paralysis, and any history that can be brought forward of recently-acquired extravagant habits, megalomania, and muscular inco-ordination, may save the victim from gaol. I have known several cases where undoubted symptoms of general paralysis have set in in persons who were serving a sentence either for indecent exposure or for theft.

Indecent Assaults by old men upon young children often have to be dealt with in our police courts. In many cases these are due to sheer depravity, but in others senile brain changes are to blame. The life history of the delinquent and also his heredities must be carefully

inquired into. In a man of hitherto blameless character, who has led a decent life and perhaps brought up a family respectably, but whose memory has latterly failed and whose temper and habits of life have altered, there is strong probability of a cerebral cause being present, especially if any heredity of insanity can be traced.

Incendiarism is not uncommon among imbeciles, and is also a well-recognised concomitant of moral insanity.

Infanticide is, as we all know, an occurrence likely to happen in the course of puerperal insanity, and it is highly important to bear in mind the fact that the mental aberration leading to this act may be of a fleeting character, perhaps lasting only for a few hours. All cases of infanticide will, of course, be sent for trial.

The friends of a person, therefore, who has been charged with or sentenced for a serious offence contrary to the tenor of his previous life should insist on medical examination by a skilled physician. This applies to a prisoner alike whether on his trial or after he has been actually sentenced.

Attempted Suicide is generally due to melancholia, often aggravated by semi-starvation and exposure, but it is not uncommon in drunkards, some of these making repeated attempts on their lives when full of drink, thus becoming a perpetual nuisance and anxiety to all their friends. I once knew a case of a gentleman, an alcoholic, who attempted suicide with a razor over and over again, never succeeding in doing more than making a nick in the crico-thyroid membrane, until one day when in the train he heard some conversation on the subject of throat-cutting, and learned that the great vessels lay to either side of the median line. He came home full of this newly-acquired information, and during his next drinking-

bout he divided his left common carotid artery with fatal effect.

Paranoiacs have committed suicide to escape from their subjective tortures and persecutions.

Imbeciles will sometimes make feigned attempts at suicide, to attract pity or to gain a temporary notoriety. Occasionally the attempt is successful, quite by accident and contrary to intention.

Drunkenness may be due to dipsomania or to an ordinary debauch in an otherwise presumably sane person. In either of these cases the delinquent's appearance in a police court is often a blessing in disguise, as he or she, in order to avoid a conviction, may take the magistrate's advice and consent to make a stay in an inebriates' home.

APPENDIX

I HAVE here appended the Statutory Forms of the Ordinary Lunacy Certificate and of the Urgency Order, thinking they may prove useful to those practitioners who have not had experience in certifying the insane.

N.B.—In all circumstances, if possible, the PETITION *and* STATEMENT *below to be filled up by the Patient's Relatives. If no Relatives, by the nearest Friend.*

[FORM 1.]

PETITION FOR AN ORDER FOR RECEPTION OF A PRIVATE PATIENT.

53 *Vict. Ch.* 5, *Schedule* 2, *Form* 1.

In the matter of (A)..... (A) Name of patient in full.
a person alleged to be of unsound mind.

To His Honour the Judge of the County Court of.....
or To ..... Stipendiary Magistrate for .....
or To ..... a Justice of the Peace for .....

The Petition of (B).....of (1)..... (B) Name of petitioner in full.
in the county of .....

1.—I am (2) ..... years of age. (1) Full postal address and rank, profession, or occupation.

2.—I desire to obtain an Order for the reception of (*name of patient in full*) ..... as a lunatic, *or* an idiot, *or* a person of unsound mind, in .....

3.—I last saw the said (*name of patient in full*)..... (2) At least twenty-one.
..... at .....on the (3) ..... day of (3) Some day within 14 days before the date of the presentation of the Petition.
..... 191...

4.—I am the (4).....of the said (*name of patient in full*) ..... (4) Here state the connection or relationship with the patient.

If the petitioner is not connected with or related to the patient, state as follows :—

I am not related to or connected with the said (*name of patient in full*) .....

The reasons why this Petition is not presented by a relation or connection are as follows : .....
.....
.....

The circumstances under which this Petition is presented by me are as follows :.....
.....

5.—I am not related to or connected with either of the persons signing the Certificates which accompany this Petition as

(*where the petitioner is a man*) husband, father, father-in-law, son, son-in-law, brother, brother-in-law, partner, or assistant ;

(*or where the petitioner is a woman*) wife, mother, mother-in-law, daughter, daughter-in-law, sister, sister-in-law, partner, or assistant.

6.—I undertake to visit the said (*name of patient in full*) ..... personally, or by someone specially appointed by me, at least once in every six months while under care and treatment under the Order to be made on this Petition.

7.—A Statement of Particulars relating to the said (*name of patient in full*) ..... accompanies this Petition.

If it is the fact, add :

8.—The said (*name of patient in full*) .... has been received in ..... under an Urgency Order, dated the (5) .....

(5) Here insert date of Urgency Order (if any).

The Petitioner therefore prays that an Order may be made in accordance with the foregoing statement.

Full Christian and surname of petitioner .....

Date of presentation .....

[Form 2.]

STATEMENT OF PARTICULARS.

Statement of Particulars referred to in the Annexed Petition.

The following is a statement of particulars relating to the said (*name of patient in full*) .....

N.B.—If any particulars are not known, the fact is to be so stated.

Name of patient, with Christian name at length	.....
Sex and age	.....
Married, single, or widowed . . .	....
Rank, profession, or previous occupation (if any)	.....
Religious persuasion	.....
Residence at or immediately previous to date hereof	.....

Whether first attack . . . . .
Age on first attack . . . . . .
WHEN and WHERE previously under care and treatment as a lunatic, idiot, or person of unsound mind . . . . (Give the dates.)
Duration of existing attack . . . .
Supposed cause . . . . . .
Whether subject to epilepsy . . . .
Whether suicidal . . . . . .
Whether dangerous to others, and in what way . . . . . .
Whether any near relative has been afflicted with insanity . . . . .
Names, Christian names, and full postal addresses, of one or more relatives of the patient . . . . . .
Name of the person to whom notice of death to be sent, and full postal address if not already given . . . . .
Name and full postal address of the usual medical attendant of the patient . . .

When the petitioner or person signing an Urgency Order is not the person who signs the Statement, add the following particulars concerning the person who signs the Statement.

Name, with Christian name at length .....
Rank, profession, or occupation (if any) .....
How related to or otherwise connected with the patient . . .

N.B.—If neither of the practitioners signing the Medical Certificates be the usual medical attendant of the patient, the reason of this must be stated in writing to the Judge, Magistrate, or Justice, by the petitioner.

[FORM 3.]

N.B.—The patient must be received into the asylum before the expiration of seven clear days from the date of the Judge's, Magistrate's, or Justice's order.

ORDER FOR RECEPTION OF A PRIVATE PATIENT, TO BE MADE BY THE JUDGE OF COUNTY COURTS, STIPENDIARY MAGISTRATE, OR JUSTICE APPOINTED UNDER THE LUNACY ACT, 1890.

I, the undersigned (*name*) .....
being the Judge of the County Court of .....
or the Stipendiary Magistrate for .....

or a Justice for ..... specially appointed under the Lunacy Act, 1890, upon the Petition of (*name of petitioner*) ..... of (*address and description*) ..... in the matter of (*name of patient*) ..... a lunatic, *or* an idiot, *or* a person of unsound mind, accompanied by the Medical Certificates of (A) ..... and (A) ..... hereto annexed, and upon the undertaking of the said (*name of petitioner*) ..... to visit the said (*name of patient*) ..... personally or by someone specially appointed by the said (*name of petitioner*) ..... once at least in every six months while under care and treatment under this Order, hereby authorize you to receive the said (*name of patient*) ..... as a patient into your hospital. And I declare that I have [*or* have not] personally seen the said (*name of patient*) ..... before making this Order.

(A) Names of Medical Practitioners signing Certificates.

Dated .....

Signed .....*Judge of the County Court of*

..... or *Stipendiary Magistrate*,

..... or *a Justice for ..... appointed under the said Act.*

N.B.—Medical Certificates of patient's examination, and the signatures, are required by the above Statute to be dated not more than seven clear days previously to the date of the presentation of the Petition.

Medical practitioners signing the Certificates must not be in partnership, nor one the assistant of the other; nor must they be related to one another, as father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister, sister-in-law, partner, or assistant; nor must they themselves sign the Petition or Urgency Order, nor must they be related to the petitioner in any of the ways specified in the petition.

One of the Certificates shall, whenever practicable, be under the hand of the usual medical attendant, if any (being a medical practitioner), of the alleged lunatic. They must use the terms specified in the Statute. (See marginal notes.)

BY ORDER OF THE COMMISSIONERS IN LUNACY.

1.—It is absolutely necessary that the medical men should write their Certificates legibly, so as to afford the opportunity of an exact copy being made.

2.—'All alterations in the original Certificates, *unless by the certifying medical men*, invalidate them; and *the initials of the latter* must be placed to every change or addition made.'

CERTIFICATE OF MEDICAL PRACTITIONER.

[SCHEDULE 2. FORM 8.]

In the matter of (*name of patient*).....
of (1) ..... in the ..... (2) of .....
(3) ..... an alleged lunatic.

I, the undersigned (*name of practitioner*) .....
do hereby certify as follows :—

1.—I am a person registered under the Medical Act, 1858, and I am in the actual practice of the medical profession.

2.—On the ..... day of ..... 191... at (4) .....
.... in the (5) ..... of .....
separately from any other practitioner, I personally examined the said (*name of patient*) ..... and came to the conclusion that he is a person of unsound mind, and a proper person to be taken charge of and detained under care and treatment.

3.—I formed this conclusion on the following grounds, viz. :—

(*a*) Facts indicating insanity observed by myself at the time of examination (6), viz. :—
.....
....
.....

(*b*) Facts communicated by others, viz.: (7) *State the name in full of the person giving the information, with the address and description* .....
.....
.....

4.—The said (*name of patient*) .....
appeared to me to be (*or* not to be) in a fit condition of bodily health to be removed to .....

5.—I give this Certificate, having first read the section of the Act of Parliament printed below.

Dated ..... 191... Signed .....
Full postal address .....
.....

(1) Insert residence of patient.
(2) County, city, or borough, as the case may be.
(3) Insert profession or occupation (if any).
(4) Insert place of examination, giving the name of the street, with number or name of the house, or should there be no number, the Christian and surname of occupier.
(5) County, city, or borough, as the case may be.
(6) If the same or other facts were observed previous to the time of examination, the certifier is at liberty to subjoin them in a separate paragraph.
(7) The names and Christian names (if known) of informants to be given, with their addresses and descriptions.

Extract from Section 317 *of the Lunacy Act*, 1890.

'Any person who makes a wilful misstatement of any material fact in any Medical or other Certificate, or in any Statement or Report of bodily or mental condition under this Act, shall be guilty of a misdemeanour.'

N.B.—By Section 28, '*Every Medical Certificate made under and for the purposes of this Act shall be evidence of the facts therein appearing and of the judgment therein stated to have been formed by the certifying medical practitioners on such facts as if the matters therein appearing had been verified on oath.*'

In the case of private patients and patients not under proper care and control, etc., two Medical Certificates are required.

URGENCY ORDER.

Form of Urgency Order for the Reception of a Private Patient into .....

53 *Vict., Ch.* 5. (*Second Schedule, Form* 4.)

I, the undersigned, being a person twenty-one years of age, hereby authorize you to receive as a patient into .... (*name of patient in full*) ..... as a lunatic, *or* an idiot, *or* a person of unsound mind, whom I last saw at (*state where patient was last seen*) .... on the (1) ..... day of ..... 191... I am not related to, or connected with, the person signing the Certificate, which accompanies this Order, in any of the ways mentioned in the margin (2).

(1) Some day within two days before the date of the order.

(2) Husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister, sister-in-law, partner, or assistant.

Subjoined hereto is a Statement of Particulars relating to the said (*name of patient*) .....

Signed

(*name and Christian name at length*) .....

Rank, profession, or occupation .....

Full postal address .....

How related to, or connected with, the patient .....

If not the husband or wife, or a relative of the patient, the person signing to state as briefly as possible—

1.—Why the order is not signed by the husband or wife, or a relative of the patient

.....

2.—His or her connection with the patient, and the circumstances under which he or she signs

.....

Dated this ..... day of ..... 191...

TO THE

N.B.—An Urgency Order remains in force for seven days from its date, but the patient must have been personally examined by the medical practitioner signing the accompanying Certificate not more than two clear days previously to the reception of the patient.

STATEMENT OF PARTICULARS.

STATEMENT OF PARTICULARS REFERRED TO IN THE ANNEXED URGENCY ORDER.

The following is a Statement of Particulars relating to the said (*name of patient in full*) .....

N.B.—If any particulars are not known, the fact to be so stated.

Name of patient, with Christian name at length . . . .

Sex and age . . . .

Married, single, or widowed . . . .

Rank, profession, or previous occupation (if any) . . . .

Religious persuasion . . . .

Residence at or immediately previous to the date hereof . . . .

Whether first attack . . . .

Age on first attack . . . .

WHEN and WHERE previously under care and treatment as a lunatic, idiot, or person of unsound mind . . . . Give the dates.

Duration of existing attack . . . .

Supposed cause . . . .

Whether subject to epilepsy . . . .

Whether suicidal . . . .

Whether dangerous to others, and in what way . . . .

Whether any near relative has been afflicted with insanity . . . .

Names, Christian names, and full postal addresses of one or more relatives of the patient . . . . . } .....

Names of the person to whom notice of death to be sent, and full postal address if not already given . . . . } .....

Name and full postal address of the usual medical attendant of the patient } .....

Signed .....

When the petitioner or person signing an Urgency Order is not the person who signs the Statement, add the following particulars concerning the person who signs the Statement.

Name, with Christian name at length .....

Rank, profession, or occupation (if any) .....

How related to or otherwise connected with the patient . . } .....

URGENCY CERTIFICATE.

N.B.—A Medical Certificate of the examination of a patient accompanying an Urgency Order is required by the above Statute, to be dated not more than two clear days previously to the reception of the patient.

The certifying medical practitioner must not be related to the person signing the Urgency Order, as husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister, sister-in-law, partner, or assistant.

He must use the terms specified in the Statute. (*See marginal notes.*)

By Order of the Commissioners in Lunacy.

1.—It is absolutely necessary that the medical men should write their certificates legibly, so as to afford the opportunity of an exact copy being made.

2.—'All alterations in the original certificates, *unless by the certifying medical men*, invalidate them; and *the initials of the latter* must be placed to every change or addition made.'

CERTIFICATE OF MEDICAL PRACTITIONER.

[Schedule 2. Forms 8 and 9.]

In the matter of (*name of patient*) .....

of (1) ..... in the (2) ..... of .....

(3) ..... an alleged lunatic.

(1) Insert residence of patient.
(2) County, city, or borough, as the case may be.
(3) Insert profession or occupation (if any).

I, the undersigned (*name of practitioner*) .....
do hereby certify as follows :—

1.—I am a person registered under the Medical Act, 1858, and I am in the actual practice of the Medical Profession.

2.—On the ..... day of ..... 191... at (4) .....
..... in the (5) ..... of .....
I personally examined the said (*name of patient*) .....
and came to the conclusion that he is a lunatic, *or* an idiot, *or* a person of unsound mind, and a proper person to be taken charge of, and detained under care and treatment.

3.—I formed this conclusion on the following grounds, viz. :—

(*a*) Facts indicating insanity observed by myself at the time of examination, (6) viz. :—

.....
.....
.....

(*b*) Facts communicated by others, viz. : (7) *State the name in full of the person giving the information, with address and description* .....
(8) I certify that it is expedient for the welfare of the said (*name of patient*) ..... [*or* for the public safety], that the said (*name of patient*) .....
should be forthwith placed under care and treatment.

My reasons for this conclusion are as follows : .....

4.—The said (*name of patient*) .....
appeared to me to be (*or* not to be) in a fit condition of bodily health to be removed to .....

5.—I give this Certificate, having first read the Section of the Act of Parliament printed below.

Dated ..... 191... **Signed** .....

Full postal address .....

(4) Insert the place of examination, giving the name of the street, with number or name of the house, or should there be no number, the Christian and surname of the occupier.
(5) County, city, or borough.
(6) If the same or other facts were observed previous to the time of examination, the certifier is at liberty to subjoin them in a separate paragraph.
(7) The names and Christian names (if known) of informants to be given, with their address and descriptions.
(8) Statement accompanying Urgency Order.

Extract from Section 317 *of the Lunacy Act*, 1890.

'Any person who makes a wilful misstatement of any material fact in any Medical or other Certificate, or in any Statement or Report of bodily or mental condition under this Act, shall be guilty of misdemeanour.'

N.B.—By Section 28, '*Every Medical Certificate made under and for the purposes of this Act shall be evidence of the facts therein appearing, and of the judgment therein stated to have been formed by the certifying medical practitioners on such facts, as if the matters therein appearing had been verified on oath.*'

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